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LINKAGES ACROSS THE CONTINUUM OF HIV SERVICES FOR KEY POPULATIONS AFFECTED BY HIV (LINKAGES)

MID-TERM PERFORMANCE EVALUATION

July 2018

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by David Hales, Kathy Attawell, Amie Bishop, and Pierre Huygens.

Cover Photo: LINKAGES-trained Peer Educators from the Bar Hostess Education and Support Programme of Kenya share information with each other. Credit: Amie Bishop, Key Populations/Evaluation Specialist for LINKAGES Evaluation.

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Mid-Term Performance Evaluation

July 2018

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ABSTRACT

The USAID-funded Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) project, implemented in 30 countries, aims to increase the availability of and demand for HIV services for key populations and strengthen national government and civil society capacity to deliver these services. The objectives of the mid-term evaluation were to: assess project effectiveness, planning, management, service delivery, and sustainability; identify constraints to implementation; and propose recommendations for improvements. Methods included review of project documents and data, key informant interviews, and country visits.

All project countries have increased key population numbers being reached, being tested for HIV, and initiating treatment. This is a considerable achievement in a relatively short time and in contexts with significant policy, systems, and structural challenges. LINKAGES is making an important contribution to national responses for key populations by raising government awareness, supporting the provision of essential HIV services, and building the capacity of local implementing partners. LINKAGES is also introducing innovative approaches and identifying promising practices with the potential to engage “harder to reach” groups, increase HIV testing uptake and yield, and improve treatment uptake and retention. However, achieving some targets has been a challenge, and losses to follow-up occur at multiple points in the HIV cascade. Key lessons include the importance of demonstrating “proof of concept” to justify national scale-up, ensuring planning is informed by sound situation analysis and data, adapting approaches to local and hyperlocal contexts, strong collaboration with public sector providers of clinical services, sustaining capacity development for organizations providing services to key populations, and strengthening structural interventions.

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ACRONYMS

APR	Annual Program Results
ART	Antiretroviral therapy
ARV	Antiretroviral
BATS	Bureau of AIDS, Tuberculosis, and STIs
CASCO	County AIDS and STI Coordinator (Kenya)
CBO	Community-based organization
CCC	Comprehensive Care Center (Kenya)
CCM	Country Coordinating Mechanism
CEDEP	Centre for the Development of People (Malawi)
CHAS	Centre for HIV/AIDS and STI (Laos)
CHMT	County Health Management Teams (Kenya)
CHREAA	CHREAA Centre for Human Rights, Education, Advice, and Assistance (Malawi)
COP	Country Operational Plan
CPFO	Centre de Promotion Femmes Ouvrières (Haiti)
CSO	Civil society organization
DATIM	Data for Accountability, Transparency, Impact, and Monitoring
DDC	Department of Disease Control
DHIS	District Health Information System
DHO	District Health Officer
DIC	Drop-in center
DOH	Department of Health
DQA	Data quality assessment
DQI	Data quality improvement
DRC	Democratic Republic of the Congo
DREAMS	Determined, Resilient, Educated, AIDS free, Mentored and Safe initiative.
EPM	Enhanced peer mobilizer
EPOA	Enhanced peer outreach approach
FANTA	Food and Nutrition Technical Assistance Project
FHI 360	Family Health International 360
FOSREF	Fondation pour la Santé Reproductrice et l'Éducation Familiale (Haiti)
FP	Family planning
FPAM	Family Planning Association of Malawi
FSW	Female sex worker

FY	Fiscal Year
GALCK	Gay and Lesbian Coalition of Kenya
GBV	Gender-based violence
HQ	Headquarters
HTS	HIV testing services
ICASA	Independent Communications Authority of South Africa
ICT	Information and communication technology
INLS	National Institute against HIV and AIDS (Angola)
INPUD	International Network of People who Use Drugs
INSP	National Institute of Public Health (Angola)
IRGT	International Reference Group on Transgender Women and HIV/AIDS
ITOCA	Integrated Technical Organizational Capacity Assessment
KESWA	Kenya Sex Workers Alliance
KP	Key population
LAB	LINKAGES Advisory Board
LaoPHA	Lao Positive Health Association
LINKAGES	Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV
M&E	Monitoring and evaluation
MESI system	Integrated Monitoring, Evaluation, and Surveillance (Haiti)
MOPH	Ministry of Public Health
MSM	Men who have sex with men
MSPP	Ministry of Public Health and Population (Haiti)
MSW	Male sex worker
MTC	Medical Technology Council (Thailand)
NAC	National AIDS Commission (Malawi)
NASCOP	National AIDS and STI Control Program (Kenya)
NASF	National AIDS Strategic Framework (Kenya)
NHSO	National Health Security Office
NSAP	National Strategic and Action Plan (Laos)
O2O	On-to-Offline strategy
OGAC	Office of the Global AIDS Coordinator
OHA	Office of HIV/AIDS (USAID)
OPI	Organizational Performance Index
PCCA	Provincial Committee for the Control of AIDS (Laos)
PE	Peer educator
PEP	Post-exposure prophylaxis

PEPFAR	President's Emergency Plan for AIDS Relief
PHO	Provincial Health Office
PIF	PEPFAR Incentive Fund
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	People living with HIV
PMP	Performance Monitoring Plan
PN	Peer navigator
PNLS	National Program to Fight AIDS (Haiti)
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
QA	Quality assurance
QI	Quality improvement
RSAT	Rainbow Sky Association Thailand
SBCC	Social and behavior change communication
SDART	Same-Day ART
SOGIE	Socio-economic status, sexual orientation, gender identity and expression
SOP	Standard operating procedure
STI	Sexually transmitted infection
SW	Sex worker
SWING	Service Workers in Group
TB	Tuberculosis
TG	Transgender
THB	Thai baht
TRC-ARC	Thai Red Cross AIDS Research Center
TSU	Technical Support Unit
TUC	Thailand Ministry of Public Health and U.S. CDC Collaboration
TWG	Technical Working Group
U=U	Undetectable=Untransmittable
UIC	Unique identifier code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNC	University of North Carolina
USAID	United States Agency for International Development
VL	Viral load
VPR	Violence prevention and response
WHO	World Health Organization
YONECO	Youth Net and Counselling (Malawi)

EXECUTIVE SUMMARY

PROJECT BACKGROUND

The Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) project is a five-year (2014-2019) President's Emergency Plan for AIDS Relief (PEPFAR)/USAID's Office of HIV/AIDS (OHA)-funded program designed to improve the availability of and demand for HIV services among key populations (KPs) – men who have sex with men (MSM), transgender (TG) people, sex workers (SW), and people who inject drugs (PWID). LINKAGES is implemented by Family Health International (FHI 360) and its core partners – IntraHealth International, Pact, and the University of North Carolina (UNC), Chapel Hill – in 30 countries in Africa, Asia, and Latin America and the Caribbean. The project encompasses situation assessment, demand for and delivery of services, capacity development, structural interventions, and strategic information and research, although the extent to which all of these are implemented at country level varies between countries. LINKAGES supports these activities through: technical assistance; development and dissemination of tools and guidelines; sharing knowledge and experience; promoting links between global and local KP networks and organizations; and collaboration and engagement with global, regional, and national government and civil society partners.

LINKAGES' goal is to increase the technical capacity of national governments and their civil society partners to provide comprehensive HIV services to KPs and their sexual partners at scale. This goal will be achieved through the following results framework:

- Result 1: Increased availability of comprehensive prevention, care, and treatment services, including reliable coverage across the continuum of care for KPs.
- Result 2: Demand for comprehensive prevention, care, and treatment services among KPs enhanced and sustained.
- Result 3: Strengthened systems for planning, monitoring, evaluating, and assuring the quality of programs for KPs.

EVALUATION BACKGROUND

The main purpose of the mid-term performance evaluation was to: a) assess the effectiveness, efficiency, and quality of the LINKAGES project at the national, provincial, facility, and community service levels; identify implementation gaps and challenges; and determine how well the project is achieving its goals, objectives, and performance targets/results; b) propose key recommendations for improvements and direction for the remaining project timeframe; and c) document lessons learned and provide recommendations to inform USAID's future directions for HIV programming focused on different KP groups.

The evaluation questions were:

1. How effective is the project in achieving its goals, objectives, and performance targets?
2. What are the project's strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?
3. What are the constraints to successful implementation?
4. How well does the project align with PEPFAR and OHA and global priorities and approaches?
5. Is there a need for a global follow-on KP mechanism?

The evaluation was conducted by a team of independent consultants between September 2017 and March 2018. Methods included review of project documents and data, interviews with key informants, and visits to six project countries (Angola, Haiti, Kenya, Laos, Malawi, and Thailand). The quality and consistency of PEPFAR indicators, project reporting, and data was one of the main limitations of the evaluation.

KEY EVALUATION FINDINGS AND CONCLUSIONS

Evaluation Question 1: How effective is the project in achieving its goals, objectives, and performance targets?

All LINKAGES countries are showing increases in the number of KPs who are being reached, being tested for HIV, and initiating treatment. Among LINKAGES countries with complete data for both Fiscal Year (FY) 2016 and FY 2017, a high percentage of them improved their year-over-year performance against four key PEPFAR indicators for female sex workers (FSW) and MSM/TG populations. Across LINKAGES countries, improvements have been consistently better for MSM than for FSW. For example, 100 percent of countries with data increased the number of FSW and MSM who were tested for HIV between FY 2016 and FY 2017, 70 percent increased case detection among FSW, and 92 percent increased case detection among MSM/TG. Similarly, 100 percent of countries with data increased the number of MSM/TG who newly initiated antiretroviral therapy (ART), and 85 percent increased ART initiation among FSW.

Among LINKAGES countries with data for both FY 2016 and FY 2017, a significantly larger number – and a reasonably high percentage – of them reached their KP_PREV¹ targets for both FSW and MSM/TG in FY 2017 than in FY 2016. There was also a notable improvement in the number and percentage of countries reaching their HTS_TST² target for MSM/TG in FY 2017, although there was no improvement for FSW. Similarly, there was an improvement in the number and percentage of countries reaching their TX_NEW³ target for FSW and for MSM/TG in FY 2017.

However, despite these improvements, the numbers reached are below PEPFAR targets, and achieving these targets is proving to be a significant challenge for the project. There are losses to follow-up between KP_PREV and HTS_TST, and between HTS_TST_POS⁴ and TX_NEW. Better analysis of data, including better understanding of the reasons for losses, is needed to inform the design of targeted interventions to address losses. (It is also important to note that some losses across the project cascade are not necessarily actual losses but rather, reflect the fact that some KPs seek care from non-PEPFAR-supported sites.) In addition, in a number of countries and for some KPs, HIV testing yield (HTS_TST_POS), i.e., the positivity rate among those tested, is low. This reflects challenges in identifying KPs who are most at risk of HIV and engaging hidden, harder-to-reach KPs, especially those in the MSM and TG communities who may be less easy to reach through outreach activities. Challenges with meeting targets also reflect challenges with target-setting for case finding, including lack of available data about known HIV positives among KPs and with the clinical services elements of the cascade, particularly in contexts where LINKAGES and other PEPFAR partners are not providing treatment.

¹ KP_PREV: Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population.

² HTS_TST: Number of key populations who received HIV testing services and received their test results.

³ TX_NEW: Number of key populations newly enrolled on antiretroviral therapy.

⁴ HTS_TST_POS: Number of key populations who received HIV testing services and received a positive test result.

Evaluation Question 2: What are the project's strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?

LINKAGES has taken a comprehensive approach to KP programming that is consistent with global best practices and experience and that encompasses both service delivery and interventions to address the drivers of HIV and the barriers to uptake of services. The approach is characterized by responsiveness to the needs of KPs, commitment to KP leadership, and community involvement in service delivery.

LINKAGES also takes a broad approach to the HIV cascade, which includes prevention as well as testing, treatment, and viral suppression, although the project could do more to promote the Undetectable=Untransmittable (U=U) message, as many KPs appear to have a limited understanding of viral suppression and the importance of viral load testing.

LINKAGES is strengthening global technical leadership through the development and dissemination of guidelines and tools to support KP programs.

LINKAGES is also making an important contribution to national HIV responses by raising government awareness of the specific needs of KPs, supporting the provision of essential HIV services for KPs, and building the capacity of local implementing partners. In many countries, LINKAGES is the first large-scale program to support HIV service delivery for KPs, especially MSM and TG communities, and has demonstrated that it is feasible to deliver HIV services to these populations. This is especially important in countries where the HIV response has largely addressed a generalized epidemic. LINKAGES has established productive partnerships with governments and is building national structures and capacity for KP programming. In addition, government partners view LINKAGES as a valuable source of technical expertise. Positive efforts have also been made to harmonize project monitoring and evaluation (M&E) with national M&E frameworks, indicators, and reporting systems, although closer alignment would be beneficial in some countries.

LINKAGES is helping to identify a range of promising practices, including use of enhanced peer mobilization and enhanced peer outreach approaches (EPOA) and of peer navigators (PNs), violence prevention and response (VPR) community networks, clinical services in drop-in centers (DICs), partnerships between DICs, community-based organizations and public health facilities, and collaboration with the police. For example, LINKAGES' experience has shown that use of oral fluids tests can increase uptake of HIV testing among KPs and, when combined with enhanced peer mobilizers (EPM), can increase testing yield. LINKAGES has also shown that the use of PNs as "case managers," combined with good collaboration between civil society implementing partners and government health facilities, is fundamental to effective completion of confirmatory testing as well as treatment uptake and retention. Given their vital contribution to the success of the project, the number of and support for PNs is inadequate in some project contexts.

LINKAGES is also introducing innovative approaches and generating lessons for future programs. In some countries, LINKAGES has implemented approaches that are new to the country or scaled up approaches that had previously only been implemented on a very small scale, such as DICs in Kenya and Malawi. In others, LINKAGES is supporting or implementing new and emerging interventions, such as oral fluid testing, self-testing, and pre-exposure prophylaxis (PrEP). A key lesson is the need to adapt the model, including its approaches to outreach and service delivery, to the country and health system context, and to the population the project is trying to reach. This, in turn, reinforces the critical importance of local situation analysis, which could be stronger in LINKAGES countries. Another key

lesson is the critical role of leadership, commitment, flexibility, and creativity of local implementing partner staff and volunteers. In some countries, strong leadership and commitment, along with a flexible and responsive approach, have enabled partners to make considerable progress despite limited resources and a difficult operating environment.

LINKAGES produces a range of publications that document project experience, but better analysis and documentation of how specific approaches have been implemented and systematic data collection before and after implementation showing why they work or do not work in different contexts or with different types of KPs, would be useful. It is equally important for these documents – and complementary presentations in other media – to focus primarily on the needs of the LINKAGES implementing partners who are looking to learn from experiences in other settings. To strengthen this focus, LINKAGES could do more to support local implementing partners to capture and document promising practices and lessons through data that could help other LINKAGES countries improve their performance.

LINKAGES has the potential to make substantial contributions to epidemic control among KPs and the overall HIV response by generating valuable lessons about effective and efficient models of service delivery and strategies that can improve uptake of testing and treatment, and treatment adherence and retention. For example, the PN-as-case-manager approach could be applied to all people living with HIV; additionally, the approach could improve treatment outcomes for other diseases, including tuberculosis and hepatitis.

A critical strength of LINKAGES is its recognition of the importance of structural interventions in tackling the underlying issues that increase HIV risk and prevent KPs from accessing HIV services, as well as its strong commitment to ensuring the safety and security of staff, volunteers, and clients and to responding to incidents affecting them. However, resource constraints have reduced the scope of the project's structural interventions. LINKAGES has focused on training for health workers to reduce stigma and discrimination in health care settings and on VPR initiatives, and these have only been implemented on a relatively small scale; there is limited evidence as yet to show how these interventions have affected outcomes such as uptake of HIV testing or ART. Little attention has been given to other structural factors that increase KP vulnerability to HIV and prevent KPs from seeking HIV services.

Organizational capacity building for civil society and KP-led organizations has been effective but has ended prematurely in some countries. Priority has been given to outreach and service delivery to meet short-term performance targets, but achieving targets at the expense of building the capacity of local organizations may undermine the long-term impact and sustainability of the LINKAGES model. LINKAGES has also strengthened capacity to deliver HIV services to KPs but more direct and ongoing technical support is required by many implementing partners. LINKAGES' approach has centered on initial training workshops and dissemination of guidance and toolkits. Although this may be sufficient for some local partners, others require more intensive support, refresher training, and follow-up. In addition, more needs to be done to empower KPs, including building leadership and management skills, as KPs remain under-represented in leadership positions in most project countries. Further work could also be done to empower KPs as consumers of health services, including through promoting better awareness of rights to health care and existing accountability mechanisms.

In most project countries, LINKAGES is delivering services in a limited number of sites and implementing structural interventions on a small scale. Although these services and interventions are making an important and positive difference in their “catchment areas,” the scale of implementation is

insufficient to enable the project to demonstrate impact or to generate robust evidence to show that interventions can be delivered at scale. In other words, the small “footprint” of the project reduces its ability to maximize its impact on the HIV epidemic in these areas and to demonstrate “proof of concept” to justify national scale-up. In project countries where resource constraints limit scale of implementation, greater consideration could be given to collaboration with the Global Fund to expand the scale and coverage of services and interventions if this is not already happening.

Micro-planning and use of data for planning and quality improvement (QI) are areas that could be strengthened. Although local implementing partners in some countries are engaging in dynamic mapping and micro-planning, there is a need to strengthen consistent application of these approaches across project countries and partners to ensure that operational planning is based on reliable, up-to-date site-level data. In addition, the venue-based approach to enumerating and assessing the needs of KPs has its limitations, as KPs who do not frequent entertainment venues (i.e., hotspots) or who are not reached through peer outreach may be missed; this applies especially to MSM and TG populations. LINKAGES has started to address this issue through virtual mapping and size estimation using tools that include social media. LINKAGES’ guidance sets out how data should be used for planning, but putting this into practice can be a challenge. Country visits and reports suggest that, in some countries, implementing partners are analyzing and using data well to adjust programming and improve performance, but in others, this is less systematic and productive, even though countries received similar technical assistance inputs; it would be useful to investigate the reasons for the differences between countries. In some contexts, significantly more also needs to be done to ensure that QI is institutionalized and contributes to improved performance.

Segmentation of services is limited, and some KPs are underserved. In some LINKAGES countries, mainly due to resource constraints, DICs use the same safe space and service delivery sites and providers for different KPs. While cost effective, this is not always ideal, as different KPs have different needs, and prefer to have their own spaces or, at a minimum, their own times. Overall, engagement with and provision of services for TG communities and PWID has received less attention than for other KPs, reflecting the epidemiology and PEPFAR priorities and targets as well as budget limitations. Although a limited focus on PWID may be appropriate in some epidemic contexts, this is not necessarily the case with the TG population. In some project countries, the main emphasis is on FSW while male sex workers are not well served.

Evaluation Question 3: What are the constraints to successful implementation?

The LINKAGES partners face a range of constraints. Key constraints that are largely outside the control of the project include targets, geographic scope, funding allocations, the priority given to structural interventions and, in some countries, the fact that the project is not designed to provide services across the full cascade of HIV prevention, care, and treatment and is one player among many players – LINKAGES focuses on prevention and testing and relies on referral to other services to provide appropriate care and treatment to KPs.

Lack of data, and weak national M&E systems, are a critical constraint. Many countries do not have accurate national or local population size estimates for KP, or disaggregated data for specific KPs across the cascade, particularly MSM and TG. There are significant gaps in other data required for project planning, resource allocation, implementation, and performance tracking. Tracking clients across the HIV cascade of care is difficult, especially after treatment initiation, in countries where systems for data-

sharing between government health facilities and project implementing partners are weak, and there is no common unique identifier for clients.

Structural challenges, including criminalization, stigma and discrimination, and violence make it extremely difficult to reach and provide services to KPs and deter KPs from seeking HIV services. There are also policy and systems challenges, including national policies that limit service delivery in specific settings or the use of specific methods or technologies, inadequate coverage of HIV services, and shortages of staff and drugs. In some countries, civil society capacity is weak and there are very few KP-led organizations, limiting the number of potential local implementing partners as well as the scope to expand and improve service delivery. A specific constraint is lack of engagement of KP leadership and communities in contexts where HIV is not their main concern.

Evaluation Question 4: How well does the project align with PEPFAR and USAID's OHA and global priorities and approaches?

LINKAGES' work at global and country levels is strongly aligned with PEPFAR and OHA priorities and approaches, and LINKAGES has a strong focus on PEPFAR's commitments to key populations. In addition, LINKAGES' approach is aligned with global best practices, and its country programs are broadly aligned with and support national priorities and policies. In some project countries, there is scope to increase collaboration with non-US government partners, in particular the Global Fund. In eight project countries, LINKAGES has supported joint PEPFAR/Global Fund KPs cascade assessments to ensure alignment of strategies, geographic targets, monitoring systems, and packages of services.

Evaluation Question 5: Is there a need for a global follow-on KP mechanism?

The high prevalence of HIV among KPs, and the factors that increase the risk of HIV acquisition for these populations, is a strong public health and human rights rationale for continued investment in HIV programs and services for these populations. Historically, USAID has made significant and enduring contributions to improving and expanding the HIV response among KPs. Given USAID's health and development expertise, it can and should continue to play an active role in ending the HIV epidemic among KPs. The following points highlight broad areas for USAID consideration in planning and implementing future KP programming.

- **Continue and expand support for comprehensive KP programs.** The LINKAGES approach, which combines service delivery, capacity development, and structural interventions, shows great promise. It recognizes and addresses the mix of health and development issues that are essential to sustained engagement with populations who are marginalized and difficult to reach. As LINKAGES implementation to date shows, progress can be slow when working with these populations. It takes considerable time and effort to improve the availability of and access to HIV-related services for KPs, to improve the delivery and quality of these services, to gain the trust of people who are accustomed to high levels of stigma and discrimination, and to provide the support needed to initiate and maintain changes in health-seeking behavior in challenging settings. LINKAGES – in close collaboration with government and civil society in project countries – has built on past investments in KP-focused programs to show how the integration of context-sensitive services, capable partners, and targeted structural interventions can be a practical roadmap for epidemic control within KP communities.
- **Strengthen the evidence base for KP programs.** There is a pressing need to address the significant gaps in HIV-related data concerning KPs. As the March 2018 update of the UNAIDS

Key Populations Atlas shows, many countries have no data or no recent data on population size estimates, HIV prevalence or core HIV prevention, testing, and treatment indicators. In addition, there is a need to strengthen situation analysis from national to community levels, including better contextual and qualitative data, to inform the design of interventions; strategic, operational, and micro-planning; and implementation research. There is also a lack of data on the effectiveness and cost-effectiveness of interventions.

- **Make the case for sustained investments in KP programs.** LINKAGES has demonstrated that working closely with national and sub-national governments can have a positive and wide-ranging impact on acceptance and implementation of HIV-related activities for KPs. However, in most countries, support for KP programs is not well established and may, therefore, be reduced or eliminated subject to changing social, political, and budgetary factors. In addition, few countries have plans or funds in place to take KP programs to scale. In the foreseeable future, sustainable HIV responses for KPs will depend on financing from both domestic and international sources, and the challenge will be to ensure sufficient national funds are allocated. There is a need for a clear “business case,” which recognizes the role of KP programs in achieving HIV epidemic control.
- **Re-energize efforts to reduce HIV-related and KP-focused stigma and discrimination.** Despite decades of work, levels of HIV-related stigma and discrimination remain high and, in many countries, KPs face additional societal stigma and discrimination. These forms of stigma and discrimination are one of the main barriers to uptake of HIV testing, linkage to care, and adherence to treatment among KPs and, consequently, undermine each stage of the HIV cascade of care. Focusing on reducing stigmatizing and discriminatory attitudes among health care workers is an important first step, but it will not address the impact of wider stigma and discrimination on the cascade or its contribution to violence and other human rights violations. From a development perspective, reducing stigma and discrimination should be a priority because of the multiple and positive effects it has on KP communities and the HIV response.
- **Accelerate the use of lessons and best practices.** LINKAGES’ experience to date suggests that the following lessons or best practices can contribute to effective HIV programming for KPs in the future:
 - Analysis and use of data for targeting, planning, implementing, and monitoring activities
 - Dynamic micro-planning
 - Strong and participatory partnerships with civil society and KP-led organizations; partnerships between these organizations and government health services
 - Use of EPM/EPOA to gain better access to networks of KPs
 - Combination of physical site and virtual approaches including index testing to improve reach and case finding
 - Use of technologies and approaches that facilitate community-based HIV prevention and testing (i.e., PrEP, oral fluid testing, self-testing)
 - Use of PNs and community-based ART to improve uptake of testing, ART initiation, and retention on treatment
 - Appropriate support and incentives for PNs and PEs as well as an optimal ratio of different types of outreach workers

- Technical and organizational capacity development for civil society and KP-led implementing partners

KEY RECOMMENDATIONS

There are two overarching recommendations relevant to “course correction” at this point in the LINKAGES project. The recommendations center around improving project performance and achieving results, and the longer-term impact of the project, specifically sustainable HIV programming for KPs.

I. Improve project performance across the cascade

- 1) **Intensify efforts to reach or exceed PEPFAR targets at the country level.** In contexts where the targets are not attainable or where they are too easily reached, LINKAGES should collect, analyze, and present data to explain why and to show how the targets should be adjusted to reflect realities on the ground and available resources. LINKAGES may also need to work with USAID to refine the target-setting approach.
- 2) **Shift the balance of project resources to frontline work.** Improving performance will require LINKAGES management to focus project resources on direct implementation at the field level. Currently, allocation of resources to frontline work varies between countries; LINKAGES should analyze current allocations in project countries and take steps to shift the balance as appropriate. Greater investment in and support for frontline work is also critical to ensure implementation at sufficient scale to demonstrate impact.
- 3) **Strengthen analysis and use of data to enhance planning and targeting of interventions.** LINKAGES needs to do more to ensure that consistent and iterative micro-planning is conducted in all project countries to generate better data and analysis on the evolving local situation, including population size estimates, to inform strategic and operational planning. Quick but effective methods, such as the site walk approach used in Malawi, should be applied across project countries. More accurate population size estimates will also enable the project to set more accurate targets and to better monitor coverage. Integrating basic, widely proven, and widely accepted QI practices such as Plan-Do-Study-Act with micro-planning exercises could be an efficient and cost-effective way to reduce the leaks in the cascade. Partners also need to better understand why there are leaks in the cascade in order to refine and adapt their approach, and LINKAGES needs to intensify support to strengthen analysis and use of data to inform planning and QI. In addition, more attention needs to be given to operations/implementation research to generate contextual data, including qualitative data, which can improve understanding of the “why” of what is happening and the “how” of making improvements. Better analysis and use of data could be useful in other areas as well, including a better understanding of how different activities relate to one another (e.g., violence prevention and HIV testing uptake).
- 4) **Extend the application of effective approaches to improve performance across the cascade.** LINKAGES should move quickly to implement or expand EPM/EPOA across all project countries, given its demonstrated ability to increase reach, uptake of HIV testing, and HIV case detection. The value of peer navigation to improve performance across the cascade has also been shown in a number of LINKAGES countries; consequently, further evolution, expansion, and documentation of this approach should be a priority, particularly the role of PNs as “case managers” for clients who need additional support to start and stay on treatment. The experience of LINKAGES PNs as case managers is also highly relevant in generalized HIV

epidemics as ART retention and viral suppression (i.e., the third 90) become increasingly important.

- 5) **Intensify efforts to reach higher risk, hidden sub-populations and give greater priority to underserved KPs.** Use of EPM/EPOA will be especially critical in reaching higher risk and hidden sub-populations, in addition to strengthening micro-planning. Reaching higher risk and hidden sub-populations will also require a better understanding of the nature and behaviors of these sub-populations. The evaluation team supports LINKAGES' plans to make more effective use of social media, index case finding, and other strategies to improve reach and case finding. LINKAGES should also give higher priority to KPs whose needs have not been well addressed to date. Although the relevant populations will depend on the given country and available funding, there are gaps in activities for TG, MSM, and PWID populations in many LINKAGES countries.
- 6) **Strengthen support for PNs and PEs.** LINKAGES needs to take a more strategic approach to PN mentorship, support, and career progression and remuneration to improve motivation and retention. Although the number and role of PEs may be reduced with increased use of EPM/EPOA, similar consideration should be given to motivation, retention, and remuneration of these individuals; if EPM/EPOA does reduce the need for PEs, there may be an opportunity to equip the remaining ones with additional skills. LINKAGES should also review strategies to ensure the safety and security of PEs and PNs, including alternative and more discreet approaches to bulky paper-based job aids and data collection tools.
- 7) **Strengthen the evidence base on context-specific models of service delivery for KPs.** LINKAGES should start to document: a) what mix of approaches to service delivery is the most effective and why; b) what will have the most impact in the short term; and c) what will be sustainable in the long term in different country contexts and for different KPs. For example, it is important to understand who currently accesses services from outreach clinical services, DICs, and static clinics and why they go to the different facilities. It is also important to understand what constitutes a practical and effective balance of stand-alone services and referral to public health facilities in different contexts. This will help to improve performance as well as inform planning and costing for scale-up.
- 8) **Build on opportunities to improve access to sexually transmitted infection (STI) services in order to increase HIV case finding.** LINKAGES is well placed to test and validate approaches to increase HIV case finding by providing better access to STI services that are appropriate in different country and health service contexts and for different KPs, and where there are reliable supplies of STI drugs. For example, the pilot use of comprehensive STI testing by LINKAGES/Angola generated a significantly higher HIV testing yield among MSM and TG individuals than other LINKAGES activities targeting those same populations. Leveraging knowledge and experience from across LINKAGES countries about the link between STI services and HIV case detection would be an effective way to improve HIV testing yield and, as the pilot in Angola found, strengthen connections with KPs who are more difficult to reach with other interventions. In some countries, approaches might include comprehensive STI clinical services in DICs (e.g., testing and treatment) while in others, it may be more feasible and sustainable to strengthen linkages to KP-friendly STI services, using PNs, for example, to facilitate client referrals. An additional benefit of improving access to STI testing and treatment, which is being explored by LINKAGES/Thailand, is its impact on PrEP uptake and efficacy.

- 9) **Enhance cross-organizational and cross-country learning.** Effective approaches to cross-organizational learning employed in some countries should be adopted across the project. LINKAGES should also consider increasing the use of direct learning and sharing of practical experience through cross-organizational mentoring within countries and cross-country learning between country teams and implementing partners.

II. Contribute to sustainable KP programming

- 1) **Demonstrate the effectiveness and cost-effectiveness of the LINKAGES model.** LINKAGES needs to generate evidence about the effectiveness and cost-effectiveness of its approach to HIV prevention, testing, and treatment among KPs, through its M&E activities and, where appropriate, special studies and pragmatic/low-cost implementation research. Demonstrating impact and feasibility are critical to support advocacy with governments and other partners for increased investment in and national scale-up of HIV services and structural interventions for key populations.
- 2) **Use LINKAGES' comparative advantage to generate increased country commitment to KP programming.** Given the time-limited nature of the project, LINKAGES country teams should initiate or accelerate dialogue and supporting analysis with government and other partners on scale-up, financing, and sustainability of HIV services for KPs. LINKAGES can capitalize on its good reputation and relationships with governments to advocate for increased domestic commitment and to broker partnerships between government and KP organizations. Action to strengthen advocacy should also be part of capacity building work with local implementing partners, in particular KP-led organizations, to ensure that these organizations have the skills required to sustain advocacy efforts after the end of the project.
- 3) **Support wider and more rapid adoption of innovative approaches and emerging interventions.** Based on its country involvement in introducing and providing technical support for innovative approaches such as OraQuick, self-testing, and PrEP, LINKAGES is well placed to advocate with government partners for the policy changes required to support wider implementation of these approaches. LINKAGES should also leverage the extensive international evidence base for key innovations to support their advocacy efforts.
- 4) **Give higher priority to building local partner capacity.** LINKAGES should shift from the creation and provision of guidance, tools, and training for local implementing partners to the provision of active and ongoing support of implementation by these partners, including the practical application of existing guidance and tools. In addition, sustained efforts are needed, particularly for KP-led partners, to continue to build the leadership, organizational and technical knowledge, and skills required to maintain KP engagement in national HIV responses. This should include the capacity for short and long-term financial planning and meaningful participation in national dialogue on HIV financing.
- 5) **Give higher priority to structural interventions.** Tackling structural barriers to access and uptake of HIV services and behavior change is central to effective KP programming. As with HIV service delivery, LINKAGES needs to support implementation of interventions to address stigma and discrimination and violence at sufficient scale to demonstrate impact and generate evidence for advocacy. With respect to current project interventions, greater efforts should be made, not only by LINKAGES but also by governments and USAID, to ensure adequate coverage of training for health workers to reduce stigma and discrimination in health facilities in project catchment areas, and to strengthen client feedback and accountability mechanisms to support

monitoring of the impact of training. VPR interventions need to focus more on addressing violence prevention and access to legal support, as well as to be implemented at sufficient scale to demonstrate they are effective and efficient. Again, implementation at sufficient scale is likely to require additional resources and greater buy-in from government and donors.

- 6) **Leverage partnerships to address wider KP needs and structural barriers.** In countries where other partners are working with KPs or related issues, LINKAGES could do more to leverage the work of other programs to address the full range of issues that concern KPs and influence their HIV vulnerability and HIV service uptake. These issues include widespread societal stigma and discrimination, harmful gender norms, sensitization of the judiciary, work on human rights and criminalization, availability of drug and alcohol treatment, and economic empowerment.
- 7) **Strengthen monitoring and reporting.** At country level, LINKAGES should continue to strengthen the M&E capacity of local implementing partners and build on efforts to harmonize and consolidate data streams and reporting systems. LINKAGES should also expand and accelerate efforts to make datasets more useful and useable in real time by the people working at the frontline of the response. In addition, LINKAGES should continue working with government health services to improve tracking of clients across the cascade. At global level, LINKAGES needs to enhance the usefulness of country and global progress reporting and, in particular, to take immediate steps to improve the quality and consistency of data – and the presentation of data – in project reports. LINKAGES should also critically assess the value of the custom indicators to determine their added value, particularly in light of the reporting burden on implementing partner and country teams.
- 8) **Improve follow-up and documentation of project experiences and lessons.** LINKAGES needs to ensure the effectiveness of project activities is monitored, assessed, and documented, including the HIV prevention activities and structural interventions that can be more challenging to track and analyze. In addition, LINKAGES is generating a range of important lessons about promising practices – OraQuick, EPM/EPOA, PNs as case managers, VPR community networks, partnerships between DICs and public health facilities, collaboration with the police – and these should be documented in practical and cost-effective ways that make them useful to interested parties within and outside the project.



Boyz Town, Pattaya, Thailand, outreach work with SWING Pattaya for MSM and transgender people. SWING staff member (transgender woman) at left talks with client at the location. Credit: Ian Taylor for FHI 360

I. INTRODUCTION

EVALUATION BACKGROUND AND PURPOSE

The Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) Project is a five-year (June 2014–June 2019) Cooperative Agreement with a budget ceiling of \$225 million funded by the United States Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR). The project is designed to improve the availability of and demand for HIV services among key populations (KPs), including men who have sex with men (MSM), transgender (TG) people, sex workers (SW), and people who inject drugs (PWID). It is implemented by Family Health International (FHI 360) and its core partners (IntraHealth International, Pact, and the University of North Carolina [UNC], Chapel Hill). USAID/Washington commissioned a mid-term performance evaluation of the LINKAGES project, which was conducted by a team of independent international and local consultants between September 2017 and March 2018.

The main purpose of the mid-term performance evaluation was to:

- Assess the effectiveness, efficiency, and quality of the LINKAGES project at the national, provincial, facility, and community service levels; identify implementation gaps/challenges; and determine how well the project is achieving its goals, objectives, and performance targets/results.
- Propose key recommendations for improvements and direction for the remaining project timeframe.
- Document lessons learned and provide recommendations to inform future programming directions for USAID's KP HIV support.

The main audiences for the evaluation report are USAID Key Populations and Rights Branch, USAID Missions with KP programming, USAID Office of HIV/AIDS (OHA) leadership, and LINKAGES project staff (FHI 360 and partners). The evaluation findings and recommendations are expected to improve activities and inform direction during the remaining project timeframe and to assist USAID in shaping the direction of future support for KP HIV programming.

EVALUATION QUESTIONS AND METHODOLOGY

The key evaluation questions were:

1. How effective is the project in achieving its goals, objectives, and performance targets?
2. What are the project's strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?
3. What are the constraints to successful implementation?
4. How well does the project align with PEPFAR and USAID's OHA and global priorities and approaches?
5. Is there a need for a global follow-on KP mechanism?

Evaluation methods included review of project documents and data, interviews with key informants, and visits to six project countries (Angola, Haiti, Kenya, Laos, Malawi, and Thailand). This report summarizes key findings, organized by evaluation question, and key recommendations. It focuses on common themes that emerged from the evaluation, based on triangulation of information from different information sources, and on areas where LINKAGES needs to take action to improve project performance, impact, and sustainability.

II. PROJECT BACKGROUND

CONTEXT: HIV AND KEY POPULATIONS

Key populations are among the most vulnerable to and affected by HIV, including in regions and countries considered to have generalized epidemics. According to *UNAIDS Data 2017*, outside of sub-Saharan Africa, KPs and their sexual partners accounted for 80 percent of new HIV infections in 2015. Even in sub-Saharan Africa, KPs and their sexual partners are an important part of the HIV epidemic: in 2015, 25 percent of new infections occurred among this group, underlining the importance of reaching them with services. In Kenya, for example, female sex workers (FSW), MSM, and PWID are estimated to contribute to 33 percent of all new HIV infections. Globally, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), gay men and other MSM accounted for 12 percent of new infections in 2015, while sex workers and PWID accounted for 5 percent and 8 percent of new infections, respectively. In regions outside of sub-Saharan Africa, gay men and other MSM accounted for 22 percent of new infections, PWID for 20 percent, SW for 5 percent, and TG people for 2 percent.

Data reported by countries across the world, captured in the latest version of the UNAIDS Key Populations Atlas, also show that HIV prevalence among KPs is often very high. For example, in LINKAGES countries, prevalence in MSM ranges from 1.6 percent in Laos to 37.2 percent in Cameroon, with rates above 10 percent in 14 countries. Few LINKAGES countries report data for TG people, but in those that do, prevalence ranges from 6 percent in Nepal to 24.8 percent in Indonesia. Prevalence among sex workers in LINKAGES countries ranges from 1 percent in Laos, for example, to 71.9 percent in Lesotho; in countries that report data disaggregated by sex, prevalence in male sex workers (MSW) is generally higher than in FSW – reported rates of HIV prevalence among MSW are 50 percent in Côte d'Ivoire, 18.9 percent in Indonesia, 16.7 percent in Kyrgyzstan, 30.8 percent in Suriname, and 12.2 percent in Thailand.

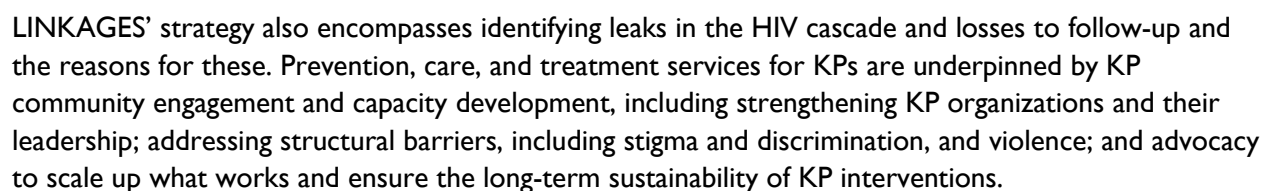
LINKAGES: OBJECTIVES, SCOPE, AND ACTIVITIES

LINKAGES' goal is to increase the technical capacity of national governments and their civil society partners to provide comprehensive HIV services to KPs and their sexual partners at scale. This is expected to be achieved through the following results framework:

- Result 1: Increased availability of comprehensive prevention, care, and treatment services, including reliable coverage across the continuum of care for KPs.
- Result 2: Demand for comprehensive prevention, care, and treatment services among KPs enhanced and sustained.
- Result 3: Strengthened systems for planning, monitoring, evaluating, and assuring the quality of programs for KPs.

The cascade of HIV prevention, care, and treatment services for KPs (see Figure 1) provides the strategic framework for the project. As Figure 1 shows, the cascade encompasses identifying and reaching KPs, ensuring that they know their HIV status, ensuring early initiation of treatment for those who are diagnosed HIV-positive, ensuring sustained treatment, and achievement of suppressed viral load (VL). The cascade is aligned with UNAIDS and PEPFAR goals: ensuring that all KPs who are HIV-positive

Figure 1. Cascade of HIV Prevention, Care, and Treatment Services for Key Populations



- *KP assessments*: Population size estimation, mapping; KP risk assessments, generating and assessing HIV cascades.
- *Service delivery and demand creation*: Financial and technical support for local implementing partners to deliver HIV prevention, testing and treatment services and other services (e.g.,

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family planning [FP], sexually transmitted infection [STI] diagnosis and treatment, and tuberculosis [TB] screening) for KPs; quality standards setting and quality assurance.

- *Capacity development*: Technical capacity building for HIV service delivery; organizational capacity building for KP organizations to strengthen leadership, advocacy, and sustainability.
- *Structural interventions*: Stigma reduction interventions (e.g., training for health care workers); violence prevention and response [VPR] interventions.
- *Strategic information and research*: Strengthening monitoring, evaluation, and data quality; implementation science and piloting of new approaches (e.g., introduction of pre-exposure prophylaxis [PrEP] and HIV self-testing); epidemiological and behavioral research.

LINKAGES supports these activities through technical assistance, development and dissemination of tools and guidelines, sharing knowledge and experience, promoting links between global KP networks and local organizations, and collaboration and engagement with global, regional, and national government and civil society partners.

FHI 360 provides overall technical, managerial, and financial oversight and specific technical expertise in KP programming, social and behavior change communication (SBCC), strategic information, and monitoring and evaluation (M&E). IntraHealth leads on capacity development for health workers in providing quality, KP-friendly⁶ services. Pact leads on capacity development for country implementing partners – specifically, civil society and KP-led organizations, and KP networks. UNC leads on mapping and population size estimation. The University of Manitoba, Canada, provides technical support to acceleration efforts and significantly contributed to the *Key Population Program Implementation Guide*.

LINKAGES coverage currently includes 30 countries in Africa, Asia, and Latin America and the Caribbean.⁷ LINKAGES supports programs for MSM in all countries except Djibouti and FSW in all countries except Laos and countries in Central Asia. Programs for the TG community are being supported in Angola, Cambodia, Côte d'Ivoire, India, Indonesia, Jamaica, Laos, Malawi, Nepal, Thailand, and countries in the eastern Caribbean. Programs targeting PWID are being implemented in Cambodia, India, Indonesia, Sri Lanka, Thailand, and countries in Central Asia.

⁶ The term “KP-friendly” is used broadly by LINKAGES and in this report to describe the combination of factors that ensure quality services appropriate to the needs of KPs are provided by competent, non-judgmental staff in non-stigmatizing, non-discriminatory ways and settings.

⁷ According to the most recent quarterly progress report, participating countries are: Africa: Angola, Botswana, Burundi, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo (DRC), Djibouti, Kenya, Lesotho (start-up in 2018), Malawi, Mali, Mozambique, South Sudan, Swaziland; Asia: Cambodia, India, Indonesia, Laos, Nepal, Sri Lanka, Thailand; Central Asia: Kazakhstan, Kyrgyzstan, Tajikistan; Latin America and the Caribbean: Bahamas, Barbados, Dominican Republic, Haiti, Jamaica, Suriname, Trinidad and Tobago.

III. EVALUATION METHODS AND LIMITATIONS

Since this was a mid-term performance evaluation, it was not intended to be a rigorous quasi-experimental design outcome or impact evaluation or to attempt to attribute changes in health outcomes or impact to the project.

Evaluation methods therefore included review of project documents and data, interviews with key informants (see Annex II: Evaluation Methods and Limitations, Annex III: Persons Interviewed, and Annex IV: Sources of Information), and visits to six project countries⁸ (see Annex V: Country Visit Reports). Criteria for country selection included: countries included in LINKAGES' Acceleration Strategy; support for technical assistance compared to support for service delivery; availability of monitoring data and results over time; targets in countries demonstrate scale; extent of country mission buy-in to LINKAGES; and plans for costing studies.

Key informants included USAID Washington staff, FHI 360 and core partner staff, a sample of LINKAGES Advisory Board (LAB) members, other donors, and technical agencies. Country visits included meetings with USAID Mission staff, national and local government officials, LINKAGES management staff, implementing partners and KP organization staff (e.g., peer navigators [PNs], peer educators (PEs) and drop-in center (DIC) staff), KP service users, health workers, and police officers. The country visits also included trips to multiple field sites to observe project activities. The evaluation team used their knowledge and experience to assess information and data collected from these various sources and to reach a consensus on the findings and recommendations.

The evaluation and evaluation methods had a number of limitations. First, it was only feasible to visit a sample of LINKAGES countries, which may not be representative of the situation in other project countries. Second, responses from local implementing partners and other informants may have been influenced by the presence during meetings, interviews, and focus groups of LINKAGES staff. Third, project data shows that progress and achievements vary, depending on the country context and the length of time and intensity of project interventions, making it difficult to identify overall trends.

Lastly, there were issues with the quality and consistency of PEPFAR indicators, project reporting, and data. Specifically, global progress reports do not provide an overview or cumulative information about what has been achieved across LINKAGES countries. These reports, and country progress reports, summarize activities in the preceding reporting period and not always in a consistent way. This makes it difficult to track changes in activities and data from quarter to quarter and trends over time as well as to understand overall achievements. For example, it is difficult to quantify how many health workers have been trained on stigma reduction in each country or how many local implementing partners have received capacity development support. There are also inconsistencies in reported data across different documents and, until more recently, data have not always been fully disaggregated by KP.

The evaluation team took steps to mitigate the different limitations, although not all could be fully addressed. For example, it was outside the scope of the team to visit additional countries, but the team did review a wide range of documents from multiple LINKAGES countries to assess the work being done there, and the data analysis conducted by the team took into account the diversity of country

⁸ Angola, Haiti, Laos, Malawi, Kenya, and Thailand.

contexts. The team also worked with LINKAGES and USAID staff responsible for strategic information to attempt to better understand the availability and accuracy of data, including correlating data from LINKAGES reports with data from the PEPFAR Data for Accountability, Transparency, Impact, and Monitoring (DATIM) system.

IV. FINDINGS

The findings included in this section of the report are based on information and data collected from visits to six LINKAGES project countries (including interviews with government, civil society, and private sector informants with knowledge of and/or engagement with the LINKAGES project; interviews and meetings with local implementing partners, health facility workers, and project beneficiaries); review of a significant number of documents and other resource materials related to project implementation and performance; review of reported project data; and analysis and triangulation of these inputs by the evaluation team.

EVALUATION QUESTION 1. HOW EFFECTIVE IS THE PROJECT IN ACHIEVING ITS GOALS, OBJECTIVES, AND PERFORMANCE TARGETS?

Overall, LINKAGES is making good progress towards its goal of building the capacity of government and civil society partners to provide comprehensive HIV services for KPs, although these services are not yet being delivered at scale or in all locations where KPs are present; this is mainly due to limited budgets or PEPFAR determination of the geographic scope of the project. Expected project results are:

- Result 1: Increased availability of comprehensive prevention, care, and treatment services, including reliable coverage across the continuum of care for KPs.
- Result 2: Demand for comprehensive prevention, care, and treatment services among KPs enhanced and sustained.
- Result 3: Strengthened systems for planning, monitoring, evaluating, and assuring the quality of programs for KPs.

Regarding Result 1 and Result 2, LINKAGES is making an important contribution to increasing the availability of prevention, treatment, and care services for KPs and enhancing demand for these services among KPs. This is, however, limited to sites where local implementing partners are operating, and the project has not yet been able to leverage achievements and lessons to expand and sustain KP programming in LINKAGES countries. Again, this is largely due to funding limitations and PEPFAR specification of focus provinces, counties or districts in project countries, in some cases to avoid overlap with other donors. Regarding Result 3, LINKAGES has established the foundations for strengthened national and civil society partner systems for planning, quality assurance, and M&E of KP programs. The next phase of the project needs to build on efforts to date to ensure that these systems are adopted and institutionalized across all project countries and implementing partners. Specific findings relating to project results and intermediate results – including planning and mapping, service delivery and referral, structural interventions, capacity strengthening, monitoring and data use, technical support, and project learning – are discussed in detail in the next section under Evaluation Question 2.

Table 1 shows the improving reach of LINKAGES global activities from Fiscal Year (FY) 2015 through FY 2017, using the Annual Program Results (APR) from DATIM. Year-on-year reach using aggregate data for all KPs has improved every year for each of the four key PEPFAR indicators. Table 2 compares the same data on reach with the PEPFAR targets for FY 2016 and FY 2017. In both FY 2016 and FY 2017, LINKAGES exceeded the KP_PREV target. It also exceeded the HTS_TST target in FY 2017. Percentage performance against the targets for HTS_TST_POS and TX_NEW were less robust but did improve between FY 2016 and FY 2017.

Table 1. Aggregate number of KPs reached by LINKAGES in FY 2015, FY 2016, and FY 2017, including year-on-year percentage change

Indicator	FY 2015 APR	FY 2016 APR	FY 2017 APR
KP_PREV	43,137	355,607 (+724%)	443,935 (+24.8%)
HTS_TST	28,726	146,199 (+409%)	360,035 (+146%)
HTS_TST_POS	2,590	9,456 (+265%)	18,440 (+95%)
TX_NEW	476	3,338 (+601%)	8,095 (+142%)

Table 2. Aggregate performance by LINKAGES against targets in FY 2016 and FY 2017, including percentage of the target

Indicator	FY 2016 Targets	FY 2016 APR	FY 2017 Targets	FY 2017 APR
KP_PREV	280,352	355,607 (127%)	312,386	443,935 (142%)
HTS_TST	205,061	146,199 (71.3%)	191,440	360,035 (188%)
HTS_TST_POS	24,514	9,456 (38.6%)	23,749	18,440 (77.6%)
TX_NEW	6,180	3,338 (54%)	9,326	8,095 (86.8%)

Data provided by LINKAGES shows that a high percentage of countries with complete data for both FY 2016 and FY 2017 improved their year-on-year performance against the four PEPFAR indicators for FSW and MSM/TG populations (see Table 3). Improvement is based on increases in the number of individuals tracked by an individual indicator. For example, 100 percent of countries with data increased the number of FSW and MSM who were tested for HIV (HTS_TST) between FY 2016 and FY 2017. Seventy percent of countries had increased case detection (HTS_TST_POS) among FSW; 92 percent had increased case detection among MSM/TG.

Table 3. Number and percentage of LINKAGES countries showing improvement in their performance between FY 2016 and FY 2017 by key population (with denominators)

	FSW	MSM/TG ⁹
KP_PREV: Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	14/16 (87.5%)	17/19 (89.5%)
HTS_TST: Number of KP who received HIV Testing and Counseling (HTS) services for HIV and received their test results	16/16 (100%)	18/18 (100%)
HTS_TST_POS: Number of KP tested HIV positive	7/10 (70%)	11/12 (91.5%)
TX_NEW: Number of KP newly initiated on antiretroviral therapy	11/13 (84.5%)	12/12 (100%)

⁹ Note that LINKAGES is now disaggregating MSM and TG data.

Again, using data provided by LINKAGES, Table 4 shows the number and percentage of countries with data for both FY 2016 and FY 2017 who achieved or exceeded their targets for the listed indicators. Among LINKAGES countries with data for both FY 2016 and FY 2017, a significantly larger number, and a reasonably higher percentage, reached their KP_PREV targets for both FSW and MSM/TG in FY 2017 than in FY 2016. There was also a notable improvement in the number and percentage of countries reaching their HTS_TST target for MSM/TG in FY 2017, although there was no improvement for FSW, and an improvement in the number and percentage of countries reaching their TX_NEW target for both FSW and for MSM/TG in FY 2017.

Table 4. Number and percentage of LINKAGES countries achieving or exceeding their targets in FY 2016 and FY 2017 (with denominators)

	FSW		MSM/TG	
	FY16	FY17	FY16	FY17
KP_PREV: Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	3/14 (21.5%)	9/14 (64%)	3/17 (17.5%)	13/17 (76.5%)
HTS_TST: Number of KP who received HIV Testing and Counseling (HTS) services for HIV and received their test results	4 /17 (23%)	5/17 (29.5%)	4/18 (22%)	10/18 (55.5%)
HTS_TST_POS: Number of KP tested HIV positive	0/10 (0%)	1/10 (10%)	0/11 (0%)	2/11 (18%)
TX_NEW: Number of KP newly initiated on antiretroviral therapy	0/11 (0%)	1/1 (9%)	2/12 (16.5%)	4/12 (33%)

However, despite the improvements, overall performance across the PEPFAR targets is a concern, and achieving targets, particularly for HTS_TST_POS and TX_NEW, is proving to be a challenge for the project. There are losses to follow-up between KPs being reached (KP_PREV) and being tested for HIV (HTS_TST) and between KPs testing HIV positive (HTS_TST_POS) and initiating treatment (TX_NEW). (It is important to note that some losses across the project cascade may reflect the fact that some KPs seek treatment and care from non-PEPFAR supported sites, rather than actual losses.) In addition, in a number of countries and for some KPs, yield of HIV-positive cases (HTS_TEST_POS) among those tested is lower than expected. This reflects challenges in identifying KPs who are most at risk of HIV and reaching hidden, harder-to-reach KPs, especially in the MSM and TG communities, and may also reflect issues with the way in which targets were determined.

EVALUATION QUESTION 2. WHAT ARE THE PROJECT'S STRENGTHS, WEAKNESSES, AND GAPS IN PLANNING, MANAGEMENT, SERVICE DELIVERY, AND SUSTAINABILITY?

Partnerships and Management

LINKAGES has established productive partnerships with national governments. In many cases, this has built on previous USAID support and relationships. LINKAGES' role in national HIV responses and its work with KPs are recognized and appreciated by government partners at national, provincial, district, and local levels in project countries. Because of LINKAGES' advocacy and expertise, government partners increasingly recognize the importance of working with KPs and providing HIV-related services for them. For example, in Laos and Thailand, government partners view LINKAGES as

an innovative project that is providing much-needed expertise in KP programming. Similar feedback was received from governments in the other project countries visited for this review. LINKAGES has also made an important contribution to strengthening national capacity for KP programming. For example, LINKAGES/Malawi has supported the development of a national policy and the establishment of a national KP technical working group (TWG) as well as ensuring that the needs of KPs were addressed in a Global Fund proposal. In Kenya, through its partnership with the University of Manitoba, which provides technical support to the National AIDS and STI Control Programme, LINKAGES has catalyzed strong national leadership for KP programming. It has supported the national KP TWG and developed a model approach for coordination at national, county, sub-county, and community levels. In addition, LINKAGES/Kenya has supported the development or adoption of guidelines and standard operating procedures (SOPs) to strengthen national KP programming. LINKAGES/Haiti has supported the development of a national PE training manual and PrEP guidelines.

LINKAGES country teams and implementing partners demonstrate strong commitment and dedication to project objectives. In general, country visits showed that LINKAGES has capable local management teams with the requisite knowledge, skills, and experience. LINKAGES' staff and implementing partners are committed to implementing a comprehensive approach to addressing the needs of KPs that goes beyond meeting targets and strives to elevate KPs into leadership positions. Implementing partners view LINKAGES as an important opportunity to address the needs of KPs. Many are doing significant and groundbreaking work with limited resources, even though LINKAGES country teams have ensured that a significant proportion of funds are allocated to implementing partners in some countries; for example, in Kenya, 70 percent of country funding is allocated to partners. PNs and PEs clearly feel a strong commitment to – and gain considerable satisfaction from – helping their peers and communities. It is also critical to recognize that LINKAGES and its implementing partner staff and volunteers often work in very difficult and often hostile operating environments, and to view project progress in the light of this reality.

The quality and effectiveness of management practices within LINKAGES vary widely based on location (e.g., HQ and country offices) and discipline. Findings about LINKAGES management practices are largely drawn from direct interactions with LINKAGES team members in the United States and the six visited countries. Project documents, including quarterly and annual reports, contain very little information about core management issues, particularly any critical analysis of management challenges and responses. At the country level, management capacity is linked closely to the knowledge and skills of the team leader. Effective leaders had effective teams and vice versa, and better overall performance, including productive relationships with the local implementing partners doing the essential frontline work; less effective leaders had less effective teams and poorer overall performance. A noticeable gap at HQ and country level – including countries that were visited and countries where only documents and data sets were reviewed – was data integrity. There were multiple issues with the accuracy, consistency, and completeness of data, which reinforced concerns about how effectively the data was being used to track and improve project performance.

Partnerships with local implementing partners and government health facilities are generally positive and collaborative. In Kenya and Malawi, LINKAGES teams have a very good relationship with their local implementing partners and take a participatory and supportive approach to management. In Laos, government officials highlighted LINKAGES' inclusive approach to program management. In other countries, such as Angola, management of local implementing partners has been more challenging, reflecting the weak capacity and limited experience of partners, and some initial

contracts were not renewed. LINKAGES and its local implementing partners have also established positive relationships with government health facilities in countries where clients are referred to clinics and hospitals for HIV services, such as confirmatory testing, antiretroviral therapy (ART) initiation, and VL testing.

Core LINKAGES partners have broadly fulfilled their expected roles, although resource constraints in project countries have reduced their scope of activity. Feedback from LINKAGES core partners suggests that FHI360 has a good working relationship with Pact and IntraHealth at the global level and in countries where Pact and IntraHealth have provided capacity development and health worker training support, respectively. There were delays with implementation of Priorities for Local AIDS Control Efforts (PLACE) studies.

The purpose and function of LINKAGES Advisory Board is unclear. The LAB, which includes representatives from KP global organizations and networks, was originally seen as part of the project's governance structure. However, interviews with some representatives suggest it is unclear whether its role is to provide oversight, to determine project direction and priorities, to provide technical advice, or to engage more broadly with KP-relevant issues. LINKAGES has involved LAB members in some project activities, such as developing KP implementation toolkits and regional strategies, but some KP partners perceive their role within the LAB, and the role of the LAB itself, to have diminished over time. In addition, available funding for global KP networks through LINKAGES has been reduced. It is unclear how country perspectives are represented on the LAB, or how LINKAGES ensures that these perspectives influence global decision-making and prioritization. LINKAGES also has Thematic Advisory Groups, focused on strategic information and on stigma, discrimination, and violence, and these contribute to strengthening partner coordination and development of tools.

LINKAGES Headquarters (HQ) has provided considerable guidance and tools to country programs, but more support is needed for implementation. LINKAGES support to country-based staff and partners has included backstopping by country managers, technical assistance visits, strengthening strategic information and M&E, and provision of a range of guidelines and tools in addition to training curricula, manuals, and SOPs. This has addressed important gaps in global guidance on implementing and monitoring KP programs. Findings from country visits suggest that LINKAGES technical support needs to shift its emphasis from provision of guidance and tools to more targeted support for in-country staff and partners to ensure that guidance and tools are actively used. This would build on the acceleration initiative, which aimed to provide targeted technical assistance to countries to apply global guidance. Moving forward, local implementing partners recommend that any new guidance or tools developed should be as simple, practical, and easy to use in day-to-day operations as possible.

LINKAGES HQ has invested significant resources in activities to strengthen global technical leadership, program implementation, and dissemination of learning. This includes production of a quarterly research digest, newsletter, success stories, and other publications; organizing webinars, knowledge exchange workshops, and regional meetings; maintaining a project website and blog; and making presentations at conferences. These activities involve considerable time and resources, and it would be useful to evaluate which are the most useful to and used by country programs and implementing partners.

Service Delivery

Implementing partners use a range of service delivery models to provide a comprehensive package of client-centered, KP-responsive services. The core community- and facility-based

approaches are similar across countries and include peer outreach, DICs, mobile and static civil society and KP-led clinics, and referral to government health facilities. In Haiti, for example, services are delivered through peer outreach, DICs, and mobile and static clinics, with DICs linked to government health facilities. In Malawi, LINKAGES delivers services through clinical outreach, DICs attached to or satellites of public health facilities, and private clinics. In some countries, demand is strong for “one-stop-shop” services based in DICs, but the degree to which this is possible depends on government policies as well as resources. Not surprisingly, the emphasis and mix of service delivery models, and the relationships between civil society and government partners, differ according to the context and the populations being reached as well as on the national policy context. For example, the range of clinical services provided by DICs varies between countries as does the extent to which they are providing or distributing ART, reflecting national policies about what can be delivered by DICs and at the community level. It will be important for country teams and implementing partners to review service delivery models, and in particular, the role of the DICs, on a regular basis to ensure that they are adapting to changes in the context and remain both relevant and cost-effective. LINKAGES reports that reviews are underway in a number of countries, with emerging evidence suggesting that the establishment of additional DICs can increase uptake of services.

LINKAGES is doing important HIV prevention work, but this is not captured in reporting.

In all countries, partners are implementing prevention activities through outreach conducted by PEs, often based out of DICs. PEs in the countries visited are well-trained and supervised and highly committed to their work. Core prevention activities include HIV and risk reduction education; distribution of condoms and lubricants; and STI screening, testing, diagnosis, and referral. Basic education is still needed in some contexts where KPs have very limited knowledge about HIV transmission and prevention – for example, in Haiti. Provision of free condoms and lubricants by PEs is highly appreciated everywhere, especially in countries where previously KPs could only access these commodities from shops and health facilities during daytime hours. In Kenya, PEs are making good use of information and communication technology (ICT) and social media, including Facebook, Twitter, apps, and SMS for peer mobilization, SBCC messaging, and providing information about services; they are also providing emergency contraception and STI screening. KP_PREV is a composite indicator that does not disaggregate by type of prevention intervention or capture the efforts put into individual prevention activities, including repeat contact with clients; it also prioritizes an offer or referral for HIV testing as the primary prevention intervention. However, HIV prevention is still critical to prevent new cases of HIV, both to contribute to epidemic control and to minimize the costs of treatment in less well-resourced countries.

LINKAGES is supporting the introduction of PrEP for KPs. LINKAGES has played a critical role in several countries in ensuring that government partners consider PrEP – where available or soon to be introduced – as an additional tool for HIV prevention among KPs. In some countries, LINKAGES is providing technical and programmatic support for PrEP piloting and implementation in collaboration with other partners and national government, including in Thailand, where more than 50 percent of those taking part in a pilot have accessed PrEP through a LINKAGES-supported site. In Malawi and Nepal, LINKAGES has provided technical assistance for development of concept notes and SOP; in Haiti, LINKAGES supported the preparation for a PrEP pilot; and in Kenya, it is collaborating with the Bill and Melinda Gates Foundation-supported JILINDE project to roll out PrEP in specific counties. Swaziland is another LINKAGES country where PrEP is being implemented for FSW and MSM.

Enhanced peer mobilization and outreach approaches can improve case finding among the harder to reach. LINKAGES has used the enhanced peer mobilization (EPM) or enhanced peer outreach approach (EPOA) to expand outreach. This approach complements targeted outreach by PEs, using a referral chain approach, which engages members of KP communities (referred to as peer mobilizers) to reach peers in their own social and sexual networks, particularly those who are hard to reach or who may not be found at traditional hotspots, and encourage them to be tested for HIV. In Laos, government and local implementing partners noted that EPM has been far more effective than traditional outreach efforts in reaching the MSM and TG communities and identifying those at elevated HIV risk. Similarly, in Thailand, local implementing partners report that use of EPM has helped to improve case detection, particularly among the “hidden” and higher-risk members of the MSM and TG communities, and the evolving work with “super recruiters” (i.e., highly effective peer mobilizers) shows great promise and has the potential to contribute to further refinement of the approach. Also in Thailand, use of the social network model is showing potential to increase testing yield; in FY 2018 Quarter 1 the yield from this approach was 11.6 percent compared with 3 percent in clients tested through mobile events and 8 percent in clients tested at community health centers. In Malawi, enhanced peer outreach is reported to have been an effective way to reach older MSM, who are more difficult to engage. Likewise, in Haiti, the most recent quarterly report notes that use of EPOA in three pilot sites achieved a yield of 11 percent of HIV-positive cases among MSM tested compared with a yield of 7.1 percent in other project sites not using EPOA. However, despite evidence that these approaches can improve case detection, expanded peer mobilization and outreach are underutilized in many project countries; LINKAGES reports that this is mainly due to inadequate funding for scale-up.

Despite progress, case finding among KPs remains a challenge in many countries. To some extent, this reflects issues with target-setting, including taking account of the number of KPs who are already living with HIV and who know their status; difficulties in reaching the hardest to reach, especially in the MSM and TG communities; and the project’s inability to address non-HIV-related concerns of KPs. LINKAGES partners as well as the reported data highlight concerns about shortfalls in identifying new HIV cases. For example, in Laos, despite improvements in uptake of testing (see below), project activities were not generating case finding to the extent that was expected. Local implementing partners and their field workers suggest that reasons could include reluctance to be tested during outreach or by an outreach worker, as clients prefer to be tested at a walk-in center by a health worker (although the opposite is often true in other countries). In Angola, some clients report that they are reluctant to be tested during outreach as sometimes this has taken place on the street, and LINKAGES/Angola is now planning to identify more locations that are low-cost and accessible and that will ensure more privacy for clients. Lower-than-expected yield may also reflect the degree to which a venue-based approach is appropriate and effective. For example, in Angola and Malawi, hotspots may not always be the best way to reach MSM and TG communities as these populations tend not to gather in fixed venues. Age disaggregation is also important. In DRC, data show that testing among older FSW generates a higher yield of cases – 14.3 percent in those aged over 50, 9.6 percent in those aged 45-49, and 8.2 percent in those aged 40-44, compared with 2.5 percent in those under 20 – suggesting that strategies need to include reaching older women, who have had longer-term exposure to HIV risk. The same was found for MSM, highlighting the need for an increased focus on HIV case finding among older MSM, as has been done in Malawi. The findings support LINKAGES plans to refine, improve and expand use of enhanced peer outreach approaches, to make better and more strategic use of social media and other online approaches, and to promote wider use of index case contact tracing and voluntary partner referral, which has been initiated in some countries, such as Côte d’Ivoire, to increase HIV case finding. In

addition, better understanding of the dynamics of KP movements and behaviors at the grassroots level, and of sub-groups of KPs who may be at elevated HIV risk, is also required to inform better targeting and case finding.

PE performance needs to be monitored and supported. In some contexts, there is considerable variation in the performance of PEs in terms of numbers of people tested, and it will be important to explore and address the reasons for this. It may potentially be more effective to have fewer, more effective PEs and to provide them with better remuneration than to have large numbers of PEs, some of whom reach and persuade relatively few people to be tested for HIV. One of the challenges in understanding PE performance, however, is measuring and assessing the number and quality of interactions required to initiate and sustain health-seeking behaviors, particularly given the various contextual factors and personal circumstances that can affect behaviors and decision-making among the target population.

Use of oral fluids tests can increase uptake of HIV testing and, when combined with enhanced peer mobilization, can increase testing yield. In Laos and Thailand, LINKAGES has introduced OraQuick testing for HIV, which tests oral fluids and is therefore quicker, easier, and less intrusive than blood-based testing and which has increased uptake of testing. In Laos, government partners cited the introduction of OraQuick as an important innovation. In the same two countries, the combination of enhanced peer mobilization and OraQuick has been shown to be an effective way to increase testing yield through improving identification of high-risk individuals and increasing testing uptake.

LINKAGES has capitalized on opportunities to introduce other innovative approaches to HIV testing, such as self-testing. LINKAGES has provided technical support for a validation study of oral self-testing in Haiti and for piloting self-testing in countries such as Cameroon, Nepal, and Thailand. Piloting of self-testing using oral fluid testing (OraQuick HIV self-test) is planned in other LINKAGES countries, such as Kenya and Malawi. Less progress has been made in project countries where changes in the policy and regulatory environment are required. Self-testing can help to address barriers to testing for KPs, including concerns about confidentiality, fear of stigma and discrimination in health care settings, and limited availability of HIV testing services. LINKAGES' plan to support national introduction and expanded availability of self-testing to increase testing reach and repeat testing is a promising initiative. Ensuring those who test positive with a self-test are immediately linked to confirmatory testing and to treatment, if needed, will be critical, and PEs and PNs will play an important role in these activities. In addition, ensuring tracking of self-testing clients for M&E purposes – including through the use of the PEPFAR HTS_SELF indicator – will be necessary but challenging.

LINKAGES is taking steps to reduce clients lost to follow-up at different stages of the cascade. As the LINKAGES cascade data shows, losses occur in most countries at almost every stage: between referral to testing and testing uptake, between initial testing and confirmatory testing, between receiving a positive diagnosis and initiating ART, and after initiating ART. LINKAGES is using a range of approaches to try to minimize these losses. These approaches include using PNs, strengthening links between civil society implementing partners and health facilities, providing clinical services through civil society implementing partners, providing ART refills at DICs and other KP-led sites, and piloting multi-month prescribing. The project is unable to address wider factors that may contribute to losses to follow-up. At this point, it is unclear whether or not community distribution of antiretrovirals (ARVs) improves retention on treatment and achievement of viral suppression. In Kenya, the combined use of

outreach and DICs has resulted in significant increases in reach and testing, and the ability to confirm HIV-reactive results in these settings has helped to reduce leaks in the earlier stages of the cascade. Innovative approaches are also being trialed. For example, in Kenya, implementing partners are providing confirmatory testing and initiating ART in hired rooms at hotspots while, in Thailand, a same-day ART pilot is being implemented to address the delays that adversely affect ART initiation and uptake.

PNs are central to the achievement of LINKAGES results. In the LINKAGES model, PNs play a pivotal role in treatment initiation and retention across the cascade. They link people newly diagnosed with HIV to confirmatory testing and ART initiation, and provide adherence and psychosocial support to ensure retention and achievement of viral suppression. In Angola, Kenya, and Thailand, for example, expanded use of PNs is helping KP clients follow through with referrals to health facilities and to remain in treatment. In Laos, the combination of EPM, OraQuick, and PNs is proving to be an effective way to increase the number of MSM and TG individuals who know their HIV status and initiate treatment. In Angola, use of PNs has increased same-day initiation of ART. In Kenya, PNs are using ICT and social media to remind clients about appointments. In addition, PNs play a key role in maintaining relationships between civil society implementing partners and health facilities. Given their vital contribution to the success of the project, the number of and support for PNs appears to be inadequate in some of the settings visited. Some PNs report that they do not feel sufficiently supported or valued and requested additional refresher training, improved incentives, and access to counseling and psychosocial support to help them cope with their work and to prevent burnout. It is also essential that PNs receive adequate mentoring and supportive supervision in addition to their initial training. The PN model, when optimally implemented, provides important lessons for strengthening the HIV response in the general population, particularly with respect to uptake of and retention on ART.

Strong working relationships between civil society implementing partners and government health facilities are fundamental to effective referral and retention. LINKAGES has demonstrated that it is feasible to establish effective partnerships between civil society service providers and public health facilities, thereby ensuring that KPs have access to essential HIV services across the cascade. Such partnerships are critical in countries where public health facilities are key providers of HIV services, including HIV testing, ART, and VL testing. The success of this approach, and of KP uptake of services, depends on the extent to which facilities are KP-friendly and quality services are provided by competent, non-judgmental staff. In Thailand, joint efforts by implementing partners and participating health facilities to ensure services are delivered in ways that support sustained engagement of KPs have improved uptake and the quality of service delivery. In Kenya, clinical and outreach teams meet regularly at DICs to discuss how to improve the links between outreach and clinical services and follow-up of clients who have dropped out; government health workers also provide supportive supervision to DIC and outreach clinicians. Experience in Kenya suggests that where outreach and DIC services are closely coordinated, situated near to and supported by government services, and essentially function as satellite sites, enrollment and retention rates are better. Similarly, in Malawi, DICs are linked to a public health “mother” facility, which has ensured close collaboration with district health structures. In some contexts, a challenge has been the requirement to work with PEPFAR-supported health facilities, as these facilities are not always KP-friendly, especially in countries where PEPFAR support has been tailored to the needs of a generalized epidemic.

The addition of HIV clinical services has expanded the reach and appeal of DICs. In Thailand, LINKAGES has been instrumental in adding clinical services, including HIV testing and STI screening, to the DIC model. This has increased their relevance and reach in a context where the need for safe

spaces has diminished; at many DICs, clinical services are now the main reason that clients come. In other countries, such as Kenya and Malawi, the need for safe spaces, especially for MSM and TG populations, remains important. In Kenya, DICs offer HIV testing; TB, STI, and cervical cancer screening; FP; post-exposure prophylaxis (PEP); and, in some settings, PrEP. In response to demand from KPs, some also offer STI treatment, ART dispensing, and treatment for opportunistic infections. The demand for this one-stop shop approach is high among KPs and may be warranted until government health facilities are more KP-friendly. Costs, cost-effectiveness, long-term sustainability, and impact on HIV priorities will, however, need to be carefully considered as the array of offered services expands.

Segmentation of services is limited and some KPs are underserved. In some LINKAGES countries, mainly due to resource constraints, implementing partner sites, such as DICs, are using the same safe space and service delivery venue and providers for different KPs. While cost effective, this is not always ideal, as the various KPs have different needs, and prefer to have their own spaces. This is especially important for MSM and TG populations, who do not necessarily feel comfortable sharing space with other populations due to concerns about confidentiality. More flexible use of sites and timing/staggering of service delivery hours may be required to retain confidentiality and offer the maximum sense of safety to clients and to enable these sites to serve more than one KP. Overall, engagement with and provision of services for TG communities has received less attention than for other KPs; LINKAGES reports that this reflects epidemiology, PEPFAR priorities and targets, and resource constraints. One exception is Thailand, where expansion of TG services through specialized facilities has been an important LINKAGES initiative. Haiti, Kenya, and Malawi are developing plans to tailor outreach and care for TG communities during the remainder of the project. In some project countries, there has been more success in reaching FSW, and this likely reflects the specific challenges of reaching MSM and MSW.

LINKAGES is starting to explore innovative approaches to increase access to and coverage of viral load testing. VL testing is generally conducted by health facilities and is, therefore, beyond the remit of the project, other than through use of PNs to ensure that clients understand the importance of and keep appointments for VL testing, and through taking samples for VL testing at DICs. One key challenge is low KP understanding of viral suppression and the importance of VL testing. The Undetectable=Untransmittable (U=U) campaign aims to address this issue and the project could promote the U=U message to ensure that KPs understand that people living with HIV (PLHIV) who are virally suppressed cannot sexually transmit the virus to others; LINKAGES reports that U=U messaging is being integrated into training for PEs and PNs. Another key constraint is the limited availability of VL testing and the time it takes to receive results. For example, in Malawi, the turnaround time for VL testing varies between sites from two to three weeks to two months. To address this, LINKAGES is developing community-based models to improve access to VL testing for KPs.

Partner provision of STI services varies. The extent to which local implementing partners provide STI services differs and often depends on the availability of funding and the capacity of partners, as well as on the availability and reliability of STI drugs through the public health system. Provision of STI services through implementing partners and DICs in some countries focuses on STI screening, with clients being referred to public health facilities for diagnosis and treatment, while in others, such as Kenya, DICs also offer STI diagnosis and treatment. Although STI diagnosis and treatment is not a PEPFAR priority, there is good evidence that STI services can be an important entry point for HIV testing and care. In Angola, screening MSM and TG clients for STI together with telephone or social media follow-up for HIV testing has proved to be a successful strategy for increasing case finding. In

Thailand, LINKAGES is working to ensure that KP-friendly government STI services are more widely available, recognizing that improving uptake of STI diagnosis and treatment will become more critical as use of PrEP increases.

More support is needed to institutionalize quality improvement. LINKAGES has invested in quality improvement (QI) and quality assurance (QA) activities but the extent to which partners focus on QI and QA is variable, particularly at the field level. In Kenya, for example, implementing partners are taking a client-centered, client-as-partner approach to QI, using Community Advisory Boards and listening exercises with peer volunteers and other KPs, to ensure that services are of high quality and meet client needs. In other contexts, significantly more needs to be done to ensure that QI and QA are institutionalized and become an integral part of partners' day-to-day work in substantive ways that lead to improved performance. For example, basic QI approaches such as Plan-Do-Study-Act can help to identify and implement actions to reduce or eliminate leaks in the expanded cascade; these approaches are being used by some but not all implementing partners depending on their capacity but should be adopted across the project.

Community and Civil Society Engagement and Capacity Development

LINKAGES has enhanced KP engagement in the HIV response. Evidence from a range of countries shows that the most effective national responses are those where KPs are partners in decision-making and in delivery of programs and services. The project has promoted KP involvement in management, leadership, and decision-making at the global level through the LINKAGES Advisory Board. At the country level, LINKAGES has supported both existing and emerging KP-led organizations, contracted KP-led organizations as local implementing partners, and encouraged all implementing partners to establish Community Advisory Boards, which include KP representatives, to guide programming and service delivery and monitor the functioning of DICs. As of December 2017, LINKAGES had 160 sub-awards in place with global, regional, and local partners; more than 60 of these sub-awards are with KP-led organizations. In Kenya, for example, seven of 18 local implementing partners are KP-led and managed and non-KP-led partners are encouraged to elevate KPs within their leadership and management. In Malawi, one of the three implementing partners is KP-led, while the others are hiring KP staff. In Thailand, the LINKAGES team has made particular efforts to establish good relationships with KP-led organizations. As noted earlier, in some countries, LINKAGES has helped to establish national KP TWGs that provide KPs with a platform to influence national policy and programming as well as enabling KP organizations to gain legitimacy and a collective voice. In some countries, such as Kenya and Malawi, LINKAGES has also supported KP participation in district coordination mechanisms. It is less clear to what extent LINKAGES has been effective in ensuring that KPs are better represented in Global Fund Country Coordinating Mechanisms (CCMs); although LINKAGES advocates for KP inclusion, the composition of CCMs is a government decision. LINKAGES knowledge management activities also promote KP engagement and participation through KP leadership on presentations, blogs, and webinars and co-authorship of scientific papers.

LINKAGES has strengthened capacity to deliver HIV services for KPs but more direct and ongoing technical support is required by some implementing partners. LINKAGES has supported local implementing partners to initiate clinical services or expand the range of services that they provide, as well as to improve delivery of existing services through building technical and M&E capacity. In Thailand, capacity building has strengthened the ability of partner organizations to provide services and meet targets; training on EPM, eCascade, and motivational interviewing have been seen as particularly useful. LINKAGES' approach has centered on initial training workshops and dissemination of

guidance and toolkits. Although this may be sufficient for some local partners, others require more intensive and ongoing support, refresher training, and follow-up. For example, partners in Angola, Haiti, and Malawi still require further capacity building in M&E. In addition, more sustained approaches to technical capacity development, for organizations, and individuals within organizations, linked to clear objectives and measurable outcomes, are required.

Organizational capacity building for civil society and KP-led organizations has been highly effective but has ended prematurely in some countries. Capacity building has strengthened the organizational and management capacity of local implementing partners. The work done by the project on capacity development, including use of the Integrated Technical Organizational Capacity Assessment (ITOCA) and Organizational Performance Index (OPI) tools and processes, combined with developing institutional strengthening plans, is highly valued by recipient organizations. Where it has been used, the OPI has shown clear, measurable improvements in the capacity of organizations receiving support. In some countries, stronger capacity resulting from LINKAGES support has enabled partners to secure funding from other donors. Unfortunately, due to resource constraints, capacity-building activities have been short-term or have ended prematurely, despite clear need and demand for further assistance. Priority has been given to outreach and service delivery to meet Country Operational Plan (COP) priorities and project performance targets, but achieving targets at the expense of building the capacity of local organizations may undermine the long-term impact and sustainability of the LINKAGES model.

Cross-organization learning contributes to capacity development. In some countries, LINKAGES brings together partners to share experiences, challenges, and good practice. This cross-organization learning has helped to build partner capacity and improve implementation, and a similar approach would be beneficial to partners in all project countries. Given the variable capacity of implementing partners within countries, consideration could also be given to peer-to-peer technical assistance, where stronger organizations mentor and provide support to those with less experience or capacity. The original scope of LINKAGES' south-to-south networking and learning has been reduced due to resource constraints. However, LINKAGES should still aim to maximize opportunities for peer-to-peer technical assistance and learning across countries, by facilitating targeted exchange visits and communication between teams and implementing partners in different countries. For example, LINKAGES/Haiti sought advice from LINKAGES/Botswana on how to support local partners to implement EPOA, which proved to be very useful. It is unclear to what extent LINKAGES is facilitating links between global KP organizations and networks and local KP-led organizations or whether strengthening links between global and local KP organizations is contributing to capacity development.

Better data is needed to assess the impact of capacity-building activities and determine future priorities. Although there are several indicators in the project Performance Monitoring Plan (PMP) that are intended to measure progress in organizational capacity building, project progress reports do not provide an overview of objectives, indicate which organizations have received what capacity development support, or provide any analysis of the outcomes of capacity development activities. LINKAGES reports that Pact conducted a capacity development assessment in 2017, which will provide data on organizations' OPI scores and priorities for future organizational and capacity development. The 2017 OPI scores will provide a baseline and a second OPI will be conducted in 2018 to identify areas of improvement and areas in need of additional support.

More needs to be done to empower KPs. In some countries, such as Thailand, implementing partners include well-established organizations that are led by or extensively involve individuals from KP

communities. Still, KPs remain under-represented in leadership and management positions in most countries, particularly those where these populations face significant levels of stigma and discrimination or their beliefs/lifestyles are criminalized, and capacity development has not focused enough on strengthening leadership and management skills among under-represented KPs. In all of the countries visited by the team, MSM and TG communities are under-represented in leadership and decision-making positions among implementing partners, and, in some cases, LINKAGES staff. Project efforts to empower KPs as consumers of health services have focused on the development and testing of the SMS² system for client and provider reporting of stigma and discrimination and experience in health care settings. Progress with implementing the SMS² system has been slow, however, with some partners reporting that it is technically cumbersome and reverting to simpler approaches, such as SurveyMonkey, to gather feedback. LINKAGES reports that SMS² will be scaled up in FY 2018, although the extent of scale-up will vary between countries depending on project resources. Further work could also be done to empower KPs as consumers of health services through promoting better awareness of rights to health care and existing accountability mechanisms. Building on existing or simpler feedback approaches and health service accountability mechanisms may also be more effective and sustainable than introducing a new system.

Structural Interventions

LINKAGES work on structural interventions has centered on stigma and discrimination in health care settings, and violence prevention and response. A critical strength of the LINKAGES program is its recognition of the importance of structural interventions in tackling the underlying issues that increase HIV risk and prevent KPs from accessing HIV services. The project has focused on interventions to reduce stigma and discrimination in health care settings and to prevent and respond to violence, since these are essential to enhancing KP uptake of services and retention in treatment and care. Less work has been done to show how these activities have affected outcomes such as testing and ART uptake, although SMS² is expected to provide information to help clarify this link. LINKAGES has also prioritized the safety and security of outreach workers, who are at significant risk of violence in many contexts (in some countries PNs and PEs reported that carrying bulky LINKAGES materials and tools increases their risk of violence and requested less obtrusive versions). At the global level, LINKAGES has developed a core training package for health workers to reduce stigma and discrimination. LINKAGES has also developed guidance on VPR and on safety and security, and participated in a multi-country gender-based violence (GBV) study in Latin America and the Caribbean.

Training for health workers on stigma reduction has been well-received but is limited in coverage. In Kenya, the core training package was adapted following a rapid assessment of stigma and discrimination in health facilities. LINKAGES/Kenya has also worked with health facilities to develop policies and procedures to reduce stigma and discrimination. In Kenya, as in other countries, the training has been highly appreciated but has not covered a critical mass of staff or facilities, and impact is compromised by frequent staff turnover. In Malawi, selected health workers have been trained in facilities located in DIC catchment areas while in Haiti, LINKAGES has tried to ensure that at least one health worker in each relevant facility has been trained in a KP-friendly approach. Feedback from local implementing partners suggests that other health staff, not just clinicians, and facility gatekeepers, such as guards and administrative staff, also need to be sensitized. While the project has, understandably, focused on the health care setting, reducing stigma and discrimination requires efforts to tackle wider societal attitudes towards KPs and people living with HIV and engagement of KPs in addressing self-stigma, all of which continue to present significant barriers to accessing HIV services.

LINKAGES has implemented VPR interventions that appear to be delivering results. Kenya has developed an advanced VPR approach for MSM and FSW, which is aligned with the National Manual on Violence. The approach includes hotlines, early warning systems, case reporting algorithms, and crisis response teams. In addition, PEs, health workers, community and religious leaders, and the police have been trained on GBV issues. KPs are being encouraged to speak out on GBV, while PEs support KPs who have experienced violence by providing first-line support and making referrals to other services. In addition, the PN approach has been extended in Kenya to include linking people who have experienced violence to legal support. As a result of training and sensitization, the police have become important partners in VPR networks and in providing protection during peer outreach. Project data from partners in Kenya suggest that, as a result of these efforts, the number of reported cases of violence has increased. In Malawi, GBV training for implementing partners, PEs, PNs, and KP clients has also resulted in an increase in reporting of GBV cases. All DICs now have crisis response teams and have or are setting up hotlines; good relationships have been established with the police, although on a small scale; and there is anecdotal evidence that incidents of violence towards FSW perpetrated by police and clients have decreased. LINKAGES/Malawi has also trained health workers and defined partner roles and responsibilities in addressing violence. In Haiti, a reporting system for GBV cases and training for police officers has been initiated but these are still at an early stage. In most countries, follow-up for individual GBV cases appears to focus on medical care and psychosocial support. Kenya is one of the few countries to also provide links to legal support.

The comprehensiveness of VPR interventions varies between countries, but in most countries, interventions have been implemented on a relatively small scale. The initial focus in LINKAGES countries has been on establishing systems to report and respond to violence; prevention interventions are less well developed. This is understandable, given the need to prioritize responding to cases of violence experienced by KP communities, and the lack of data to inform planning for violence prevention. GBV cases are under-reported in most countries, particularly by FSW, MSM, and TG people, and in contexts where the police may be among the perpetrators of violence. As LINKAGES learns more from implementation experience and collects better data on the nature and prevalence of violence, this should help to inform planning of prevention interventions. No LINKAGES countries are implementing VPR interventions at scale, due to resource constraints, but coverage needs to be expanded if these interventions are to have a real impact on violence and its role in the HIV epidemic.

The outcomes of health worker training on stigma and discrimination and VPR interventions are not systematically captured. As noted earlier, progress with implementing the SMS² system has been slow and LINKAGES has not yet developed a systematic approach to monitoring and evaluating the effectiveness of health worker training or its impact on reducing stigma and discrimination in health care settings, although this is reported to be a LINKAGES priority in FY 2018. There is some anecdotal evidence from Malawi and Angola of the effectiveness of training and, in Thailand, it is reported that efforts to make health facilities more KP-friendly have changed KP attitudes to seeking health care. In Haiti, the project is using a mystery client methodology to assess the quality of services provided to KPs following training. In most settings, the custom indicators developed to measure outcomes related to GBV and VPR have not yet been introduced; therefore, it is not yet possible to evaluate the effectiveness and impact of VPR interventions.

Other structural issues are less well addressed. Depending on the context, and the KP concerned, other structural interventions are required to reduce vulnerability to HIV and barriers to accessing services. These include addressing harmful social and gender norms; access to legal, drug, and

alcohol services; provision of nutritional support; and economic empowerment. Given limited resources, it is not feasible for the project to address all of these issues (although in Kenya some partners are providing drug and alcohol counseling and advice on group savings and small business development, while in DRC, partners have established KP savings groups). There are examples of country programs where LINKAGES has facilitated links with other service providers and leveraged support from other partners; for example, the Food and Nutrition Technical Assistance Project (FANTA) Project in Malawi is providing nutrition support, and this approach could be adopted more systematically across the project through stronger engagement with other donors and development partners. LINKAGES could also do more to engage with the justice system, human rights organizations, and others in project countries who are working to address criminalization and increase access to justice.

Planning and Strategic Information

There is a strong commitment within LINKAGES to collect, analyze, and use data for planning, monitoring, and improving performance. This has been supported by a range of activities, including the development of dashboards and data visualization tools to support the aggregation, analysis, and display of data at global and country levels, M&E training for LINKAGES and implementing partner staff, data quality assessments (DQA), and data quality improvement (DQI) exercises. Data tools, such as eCascade and eCascade View, are beginning to have an important impact on how implementing partners collect, analyze, and use data. In Thailand, for example, the eCascade management information system is giving partners access to real-time data to help identify and address breaks in the cascade. LINKAGES has also pre-tested virtual mapping tools in Cambodia, India, Indonesia, Malawi, Nepal, and Swaziland, and supported the development of a density mapping app, which reduces the time required for data collection and provides more accurate comparisons of density.

There is an overreliance on indicator data to understand and address project performance. LINKAGES collects and reports data on a wide range of indicators, including PEPFAR indicators, LINKAGES custom indicators, and other output metrics. However, a lack of data on the underlying factors that explain the “why” behind the indicator data is often either not documented or used to address weaknesses in project performance. For example, in Quarter 3 of FY 2017, the LINKAGES dashboard for Haiti shows that linkage to ART for FSW is significantly higher for women ages 50+ (79 percent) than for woman ages 25-49 (52 percent) or ages 20-24 (37 percent). But there is no information on why these differences exist and what factors need to be addressed to improve linkage to treatment among younger FSW. Indicator data is valuable to track current performance and trends in performance but effective analysis and use of the data hinges on understanding the “why” underpinning the data.

It is too early to determine the added value of the LINKAGES custom indicators.

LINKAGES developed a set of custom indicators with the intention of capturing more information on a broader range of interventions implemented by project partners. The custom indicators were designed to supplement the core PEPFAR indicators that are the primary metrics used to assess project performance. Given that the custom indicators are still being rolled out, including ongoing work to build them into the LINKAGES dashboard, it is too early to tell how – and how effectively – the data will be collected and used. The added value of these indicators may be outweighed by the opportunity cost of not conducting better analysis of existing data and the burden on implementing partners of additional data collection and reporting.

LINKAGES has made an important contribution to strengthening HIV M&E for KPs at national level, but there are significant data gaps. For example, LINKAGES has contributed to joint national cascade assessments in partnership with governments, PEPFAR partners, and the Global Fund in a number of project countries, with eight assessments being conducted in 2017 alone. Nevertheless, lack of accurate national population size estimates for KPs continues to be a problem in many LINKAGES countries, as is the lack of disaggregated data for specific KPs across the cascade, particularly MSM and TG. In some countries, LINKAGES only focuses on some KPs, which means that data concerning other KPs are not being collected or used. For example, relatively few LINKAGES countries are addressing gaps in data on TG or MSW populations, as disaggregated data was not allowed by PEPFAR until 2017 and few are funded to reach these populations. Without data to provide evidence, the needs of these specific populations will not be addressed by government or development partners.

Lack of accurate local/hyperlocal population size estimates and robust situation analysis has been a constraint to effective planning. “Knowing your epidemic,” including having accurate local population size estimates and conducting situation analyses, is critical to effective micro-planning. Although LINKAGES has conducted regular programmatic mapping to define the locations and numbers of KPs, lack of accurate population size estimates for KPs at a very local level (and of data on behaviors and practices of KP sub-groups) is a challenge, undermining the extent to which country teams and their partners can plan, identify coverage and scale-up requirements, and assess performance. The UNC Priorities for Local AIDS Control Efforts (PLACE methodology has been implemented in seven project countries (Angola, Côte d’Ivoire, DRC, Haiti, Malawi, and Mozambique – and Burundi prior to LINKAGES). The extent to which PLACE has been useful and used to inform planning varies. In some countries, the PLACE process has been lengthy and LINKAGES teams and partners have had to start implementation before the results were available. In Haiti, the results of hotspot mapping and size estimation using PLACE provided a solid foundation for early project planning and targeting of sites. In contrast, in Angola, the results were not available prior to project planning; in Malawi, mapping was only done for FSW sites; and in Côte d’Ivoire, mapping was only done in Abidjan, the capital city.

Dynamic local mapping and micro-planning is informing better planning. There is clear evidence that local implementing partners in some countries are engaging in mapping and micro-planning. In Kenya, for example, implementing partners have made good use of mapping to plan service delivery to increase coverage. In Malawi, LINKAGES developed the “site walk” approach, which has improved size estimation and identification of hotspots and, hence, improved the number of KPs reached; this shows that when mapping is done by outreach workers in their catchment areas it helps both to improve site identification and to strengthen ownership of this method of planning. In Haiti, partners are using GPS and PE-led assessments to identify new service delivery sites and to update hotspots. Still, there is scope to strengthen application of mapping and micro-planning and ongoing, consistent use of these approaches across project countries and partners to ensure that operational planning is based on reliable, up-to-date site-level data.

The venue-based approach to enumerating and assessing the needs of KPs has its limitations. With this approach, KPs who do not frequent hotspots or who are not reached through peer outreach may be missed – this applies especially to MSM and TG populations. To address this, LINKAGES has started to use ICT for virtual mapping and size estimation in countries such as Cambodia, India, Kenya, and Nepal and scale-up of this approach is planned in several countries. LINKAGES’ plans to refine assessment and size estimation using virtual methods and tools, including

social media, and to identify KP sub-populations who may not be reached at physical sites, is another promising initiative if it remains focused on practical issues relevant to day-to-day operations in the field.

Analysis and use of data to improve performance is well-managed in some countries but could be strengthened in others. LINKAGES guidance sets out how data should be used for planning, but putting this into practice can be a challenge. Country visits and reports suggest that in some countries, implementing partners are analyzing and using data from a range of sources (e.g., programmatic mapping, micro-planning, and program monitoring) and making good use of this to adjust programming and improve performance, but in others this is less systematic. In Haiti, partner capacity to use data has been strengthened and this has improved targeting of outreach efforts. In Kenya, cascade monitoring at site level has been essential to track reach and yield by location and by KP and to identify clients potentially lost to follow-up, and PEs are using data to improve their work. In Malawi, data are being used to guide and improve programming by DICs, PNs, and PEs. In the countries visited, the introduction of the data dashboard has been fundamental, although some of the basic key indicators are not yet included in the dashboard. Partner analysis of data is limited in some contexts. In addition, the reasons for leaks in the cascade or under-performance are not always systematically investigated, nor are they always contextual or is qualitative data always collected. For example, enrollment of MSM in Haiti is sub-optimal and MSM drop-out from treatment is high, but the reasons for this have not been systematically investigated or documented. Lack of in-depth investigation of the reasons for drop-out or loss to follow-up also appears to be an issue in some of the other countries visited and, based on quarterly reports, in other LINKAGES countries as well.

Good support has been provided to develop implementing partner M&E capacity and to improve data quality and verification. It is important to note that initially, most local implementing partners were only reporting on the number of people reached with prevention activities and some process indicators; there has been considerable progress in moving towards tracking across the cascade despite the challenges this entails. LINKAGES has provided significant training and supervision and, in general, partners do a good job of collecting and reporting on data. LINKAGES has also made considerable effort to ensure data quality and verification. In Laos and Thailand, for example, LINKAGES has conducted training and carries out site visits to provide technical support and independent verification of data. In Kenya, LINKAGES has supported implementing partners to improve data quality through DQAs and has introduced effective systems of data verification. Data have been de-duplicated and data on MSM and MSW and on testing vs. re-testing have been disaggregated. In Malawi, training, mentorship, and technical assistance for implementing partners has significantly improved data quality. Across project countries, partners are increasingly disaggregating data on MSM and TG clients. Partners continue to request support for further strengthening of their M&E capacity and to ensure that other staff, not just M&E staff, are trained. In addition, limited skills and capacity of civil society partners, low literacy of volunteers, and the time and workload involved in tracking clients and recording and entering data can be challenges. Some partners highlighted specific concerns about use of the CommCare platform as it involves duplication of data entry, but others value its utility in capturing data from clients.

There are challenges in tracking clients across the HIV cascade. Challenges are due to factors such as national policies, multiple record-keeping systems, weak links with referral facilities, and lack of a common unique identifier code (UIC). In Haiti, LINKAGES does not currently track clients who may be lost between an initial reactive test during outreach and confirmatory testing, which must be done at a health facility and, because the UIC does not extend to the treatment side of the cascade, it is difficult for implementing partners to track clients after they have been referred for treatment. Similar challenges

are reported in other countries, particularly with tracking clients after they have initiated treatment. In some cases, this is because PNs are unclear about their role in tracking clients once they have entered the health system and are “outside the project,” although LINKAGES is trying to address this through better training and improved collaboration with public health service providers. In addition, some clients seek treatment outside of LINKAGES catchment areas or change their names to protect their confidentiality and so may be counted as having dropped out of treatment when, in fact, they are accessing treatment elsewhere. LINKAGES’ ability to improve tracking is limited in many settings, as system reforms require government-led changes in policy, operations, and data systems.

Good efforts have been made to harmonize project M&E with national M&E frameworks, indicators, and reporting systems but closer alignment would be beneficial in some countries. In Haiti and Malawi, LINKAGES M&E is harmonized with national data collection and reporting systems and, in Kenya, program monitoring now uses national indicators and methods. In Laos, LINKAGES is supporting the harmonization and merging of data from multiple sources. In these and other LINKAGES countries, efforts to ensure that data are reported to the national District Health Information System (DHIS) 2 platform are underway or under consideration. Feedback also suggests that LINKAGES country programs are sharing data with government officials and using these data to advocate for increased commitment to KP programming.

LINKAGES produces a range of publications and uses a range of methods to document project experience. These approaches, including webinars, abstracts, blogs, and country success stories are useful for sharing success stories with the global health and HIV community. Understandably, they focus on what has been achieved, but better analysis and documentation of how specific approaches have been implemented and why they work, or do not work, in different contexts and with different KPs, would also be useful for other implementing partners and for other LINKAGES countries. In addition, LINKAGES could do more to support local implementing partners to capture and document their experience, including promising practices and lessons learned, in ways that could help other LINKAGES countries improve their performance.

Sustainability

The LINKAGES approach is dependent on the use of volunteers to reach, test, link, and retain KP clients and this may not be sustainable. As with other cadres of community volunteers, motivation and retention is a challenge. Some PEs and PNs report that their current allowances are insufficient. Partners in Haiti report reduced PN and PE motivation due to low allowances, while those in DRC report improved performance following enhancement of allowances. In some LINKAGES countries, volunteers are using their own cell phones and the incentives and allowances they receive are insufficient to cover the basic costs of their work. For example, travel to hotspots and accompanying clients to health facilities is not reimbursed, and this is leading to drop-out and high turnover of volunteers. The problem is exacerbated where other partners, including United States government partners, provide higher incentives, although PEPFAR and the Global Fund, for example, have worked together in some countries to ensure that remuneration rates are aligned. Long-term sustainability will depend on adequately supporting PEs as well as professionalizing the PN cadre as case managers and ensuring that they are properly rewarded. This, in turn, will require that civil society and KP-led organizations secure funding beyond the project timeframe.

LINKAGES has established the foundations for a sustainable HIV response for KPs through partnerships with government and capacity development for local implementing partners.

LINKAGES has good working relationships with national and sub-national government partners and it has used this to increase government leadership, ownership of data, and commitment to KP programming. As noted earlier, LINKAGES capacity development has enabled local implementing partners to access funding from other sources. For example, in Kenya, several LINKAGES implementing partners have been selected as partners for the JILINDE Project implemented by JHPIEGO to introduce PrEP in their settings, while others have successfully accessed funds from the Open Society Foundation and the Global Fund.

Civil society organizations, especially those that are KP-led, remain highly dependent on international donor funding for their activities. LINKAGES has been working with partners to develop other models of operation to ensure future sustainability. For example, in Thailand, fee-based services in clinics are operated by civil society organizations and receive reimbursement from the National Health Security Office for services delivered. However, most organizations will still require external funds during the next five years. If international donor support is reduced, sustainability will depend on domestic government funding. In most LINKAGES countries, future government commitment to sustaining currently donor-funded civil society and KP-led HIV activities, in particular the Global Fund, is uncertain. In others, such as Thailand, there is a shift towards domestic funding mechanisms, but civil society organizations face challenges in accessing government funding through these mechanisms.

LINKAGES could do more to leverage its expertise and reputation, and available data, to advocate for increased government investment in KP programming. A key challenge is increasing national ownership and uptake of the LINKAGES approach. Advocacy should be supported by robust evidence about the effectiveness and cost-effectiveness of interventions and the resources required to implement these interventions at scale, through the development of a strong “business case.” Building on its existing support for TWGs, development of guidelines, and participation in Global Fund processes, LINKAGES is well placed to encourage increased government funding, by providing technical support for social contracting and other domestic funding mechanisms, and by strengthening KP leadership and advocacy skills. In countries where it is not already doing so, LINKAGES could leverage its good relations with governments and KP organizations to broker partnerships and ensure that KPs are fully engaged in national policy, decision-making, and technical structures. This will need to be done in partnership with other partners and programs with a similar agenda, for example, the Health Policy Plus Project. Sustainability will also require fostering and strengthening civil society infrastructure, especially KP-led organizations in countries where these organizations are still relatively new and few, through ongoing organizational capacity development. LINKAGES reports that capacity development efforts this year will include working with civil society implementing partners on sustainability, including supporting them to identify business opportunities and develop business plans. In addition, working to engage the private sector in countries where this is appropriate, such as Thailand, will also contribute to sustainability.

EVALUATION QUESTION 3. WHAT ARE THE CONSTRAINTS TO SUCCESSFUL IMPLEMENTATION?

The following summarizes key constraints to implementation that are largely outside the control of the project.

Inadequate resources to deliver interventions at sufficient scale and intensity in catchment areas. The main constraint for LINKAGES is limited funding at country level to deliver interventions at sufficient scale and intensity in project catchment areas. The small “footprint” of the project prevents it

from maximizing its impact on the HIV epidemic in these areas and from demonstrating “proof of concept” to justify national scale-up. Resource constraints have also limited the scope of LINKAGES activities in project countries. Organizational development and structural interventions have tended to be the first areas of activity to be cut, because of the focus on achieving service delivery targets. In addition, in Kenya, for example, resource constraints have prevented LINKAGES from extending effective interventions to include TG, MSW, and PWID populations, and have limited implementation of structural interventions, technical assistance, and capacity building for KP-led organizations. In Malawi, resource constraints limit the project’s ability to meet requests from the Malawian government and the Global Fund to provide technical support and to replicate the LINKAGES approach in additional districts.

Criminalization of homosexuality, sex work, and drug use. Criminalization deters KPs from seeking HIV services, creates challenges for reaching and providing services to KPs; reinforces harmful social and gender norms; and legitimizes stigma, discrimination, and violence. In some contexts, it may reduce the willingness of health workers to engage with KP issues. Public discourse about criminalization or efforts to decriminalize, though important, can often result in backlash against KPs, making their lives even more difficult and unsafe. Criminalization can also create challenges in working with the police and in building trust between KPs and the police, for example, to increase KP reporting of GBV cases.

Pervasive stigma and discrimination. Societal stigma and discrimination towards KPs remains widespread in LINKAGES countries, making it difficult to reach target populations and, in some countries, to recruit PEs and PNs. In multiple countries, reaching MSM is reported to be especially difficult due to significant social stigma. High levels of stigma and discrimination are reported to contribute to KP unwillingness to be identified. Reaching the TG population is very challenging in all countries because of stigma and discrimination. Fear of stigma and discrimination in health care settings, from health workers and other patients, continues to prevent KPs from accessing HIV services. Self-stigma within KPs and persistent HIV-related stigma and discrimination are additional constraints. In addition, stigma and discrimination reinforce the exclusion, poverty, and low social status of KPs as well as limiting educational, housing, and employment opportunities, all of which increase their vulnerability to HIV.

Widespread physical and sexual violence. Violence towards KPs is widespread in many LINKAGES countries and few countries provide post-GBV services. In Angola, as in many settings, physical violence and sexual harassment is so common that many MSM and FSW perceive it to be normal. Violence is a constraint to seeking services and to delivery of services, especially outreach services, in contexts where PEs and PNs or their clients may be targets of violence. In Haiti, outreach work and VPR interventions are reported to be difficult in areas of Port-au-Prince that are controlled by gangs.

Specific challenges of working with KPs. In addition to challenges associated with stigma and discrimination, criminalization, and violence, increasing HIV testing, treatment, and retention among KPs requires more intensive and sustained efforts than working with the general population. This is even more the case in countries where HIV is not a priority for KPs relative to other concerns. However, the metrics used to track LINKAGES performance do not reflect the additional efforts required, and the numbers do not reflect the processes required to achieve them. This is exacerbated in some contexts by under-reporting of KP status at ART sites not operated by LINKAGES. The country context for KP programming also has an effect. For example, in countries with more longstanding KP programs, such as Thailand, the relatively easy-to-reach will have already been reached and LINKAGES is trying to go

beyond the “low-hanging fruit” to reach the most hidden and marginalized KPs. It is also important to recognize that it takes time to change behaviors among KP and attitudes among the wider population; reducing stigma and discrimination, changing social norms, and addressing other structural issues are a long-term task.

Weak civil society capacity. In some LINKAGES countries, civil society infrastructure is weak; few KP-led organizations exist; and where they do, their capacity is limited. For example, in Angola and Laos, the small size and limited capacity of the civil society sector is a constraint to delivering services to the MSM and TG communities. The project also must strike a difficult balance when selecting local partners. Well-established, experienced organizations that can meet the requirements of a donor such as USAID may not always be best placed to reach harder-to-reach, hidden, younger or more mobile KPs, but partners that can engage with these sub-populations may have less capacity. The limited number of potential partners, together with the time required to build capacity and resource limitations, are also constraints to expanding and improving service delivery.

National policies that limit service delivery and retention across the cascade. National policies that, for example, prevent or limit rapid testing, self-testing or service delivery by lay providers are a constraint in a number of LINKAGES countries. For example, all countries visited can offer rapid testing in the community but, in some, confirmatory testing can only be performed in health facilities. In Laos, the government has not approved community distribution of ARVs or private sector provision of HIV testing and treatment, while in Thailand, the government has not yet approved use of OraQuick or PrEP and both remain at the pilot stage, despite being shown to be effective in research and operational settings elsewhere. In Haiti, national policy prevents community-based confirmatory testing, which increases the risk of clients being lost after a reactive test but before their diagnosis is confirmed at a health facility. In Malawi, DICs are only allowed to provide HIV testing services if they are linked to a government health facility. In Thailand, clients are required to receive treatment in the location where they are registered for health care. Changing registration to another location is complex, and this is a constraint to retention in treatment and care of highly mobile clients.

Health system weaknesses. In most project countries, achievement of results related to ART and VL testing depends on the effectiveness of public health services, over which LINKAGES has little control. Successful implementation is constrained by health systems weaknesses in many LINKAGES countries. These include shortages and high turnover of trained health care workers, inadequate coverage of health infrastructure and services, and stockouts of drugs and commodities. In Laos, there are only 11 clinics providing ART in the whole country. In Kenya and Malawi, the project has been affected by stockouts of STI drugs and in Haiti, by shortages of condoms.

Data challenges. As discussed earlier, many countries do not have accurate population size estimates for KP. As the updated UNAIDS Key Populations Atlas shows, there are significant gaps in population size data as well as in other KP-related data across all regions, which could be important for project planning, resource allocation, implementation, and performance tracking. In addition, there is limited understanding of the dynamics of sub-populations of KPs and limited behavioral data to inform planning and targeting of interventions.

Inadequate systems to track clients across the cascade. KPs are often highly mobile and follow-up is challenging. In some settings, clients may seek care from a health facility that is not close to their home, to avoid being identified. Tracking clients across the HIV cascade of care is especially difficult in countries where there is no national UIC system or where there are multiple health management

information systems, such as in Thailand. Developing an effective tracking system that allows for safe, confidential follow-up of clients is also challenging. For example, KPs in Haiti have expressed concerns about plans to introduce a new fingerprint ID system while in Kenya, many MSM and MSW are not supportive of a proposed biometric ID system.

Lack of private sector engagement. In many LINKAGES countries, involvement of the private for-profit sector in provision of HIV services for KPs is limited. While this may reflect the fact that some services provided by LINKAGES are not routinely available within the private sector, the size of the private sector – for example, the private health sector in Laos is small – or the socio-economic status of KPs, it may also represent a missed opportunity to increase the availability and coverage of services for those who are willing and able to pay. Global experience has shown that the private sector can play an important role in the HIV response for some KPs, including those who prefer private providers for reasons of confidentiality and anonymity. Lessons learned from project experience, for example, in Thailand, where LINKAGES has recently added a private clinic to its network, could inform engagement of the private sector in other countries.

EVALUATION QUESTION 4. HOW WELL DOES THE PROJECT ALIGN WITH PEPFAR AND OHA AND GLOBAL PRIORITIES AND APPROACHES?

LINKAGES' work at global and country levels is strongly aligned with PEPFAR and OHA priorities and approaches. LINKAGES is particularly closely aligned with priorities related to KPs, sustainability and partnerships, and data for impact. The project's use of an expanded HIV cascade of care to plan, implement, and monitor its activities also reflects its alignment with the PEPFAR and OHA commitment to ending the HIV pandemic through meeting the 90-90-90 and 95-95-95 targets by 2020 and 2030, respectively.

LINKAGES has a strong focus on PEPFAR KP commitments. The PEPFAR commitment to increasing KP access to and retention in quality HIV prevention, treatment, and care services and strengthening organizations meeting the HIV-related needs of KPs underpins LINKAGES' approach and activities. The project has a strong focus on improving delivery of essential HIV services for KPs. In line with the PEPFAR approach, LINKAGES also recognizes the need to address underlying issues that prevent KPs from accessing services, including human rights violations, stigma and discrimination, and violence. This is reflected in project interventions to create non-stigmatizing health care settings and to prevent and respond to violence, although these are limited in scope by availability of funds.

LINKAGES is aligned with global best practice. LINKAGES is consistent with, and in some cases has contributed to, the policies and guidelines of international partners and technical agencies, including the Global Fund, World Health Organization (WHO), and UNAIDS, and has established strong partnerships at global levels, including with global KP networks. In some countries, there is scope to increase collaboration with non-US government partners, in particular the Global Fund. In eight project countries, LINKAGES has supported joint PEPFAR/Global Fund KP cascade assessments to ensure alignment of strategies, geographic targets, monitoring systems, and packages of services – and this approach should be built on.

LINKAGES' country programs are broadly aligned with and support national priorities and policies. There are a few minor exceptions to this, which are mainly due to differences between PEPFAR and country guidelines and indicators. For example, in Kenya, there are differences in HIV testing policy. In some countries, LINKAGES is actively influencing national priorities through advocacy for increased responsiveness to KP in the national HIV response. The project has established productive

partnerships at country level, including with national and sub-national governments, civil society and KP organizations and community groups, health facilities and health providers, and, in some countries, with the police and the private sector. Considerable efforts have been made to strengthen the capacity of local implementing partners and to strengthen data collection and monitoring.

EVALUATION QUESTION 5. IS THERE A NEED FOR A GLOBAL FOLLOW-ON KP MECHANISM?

The high prevalence of HIV among KPs, and the factors that increase the risk of HIV acquisition for these populations, is a strong public health and human rights rationale for continued investment in HIV programs and services for these populations. Historically, USAID has made significant and enduring contributions to improving and expanding the HIV response among KPs. Given USAID's health and development expertise, it can and should continue to play an active role in ending the HIV epidemic among KPs. The following list, in addition to the specific recommendations in Section V of this report, highlights broad areas for USAID consideration in planning and implementing future KP programming.

- 1. Continue and expand support for comprehensive KP programs.** The LINKAGES approach, which combines service delivery, capacity development, and structural interventions, shows great promise. It recognizes and addresses the mix of health and development issues that are essential to sustained engagement with populations who are marginalized and difficult to reach. As LINKAGES implementation to date shows, progress can be slow when working with these populations. It takes considerable time and effort to improve the availability of and access to HIV-related services for KPs, to improve the delivery and quality of these services, to gain the trust of people who are accustomed to high levels of stigma and discrimination, and to provide the support needed to initiate and maintain changes in health-seeking behavior in challenging settings. LINKAGES – in close collaboration with government and civil society in project countries – has built on past investments in KP-focused programs to show how the integration of context-sensitive services, capable partners, and targeted structural interventions can be a practical roadmap for epidemic control within KP communities.
- 2. Strengthen the evidence base for KP programs.** There is a pressing need to address the significant gaps in HIV-related data concerning KPs. As the March 2018 update of the UNAIDS Key Populations Atlas shows, many countries have no data – or no recent data – on population size estimates, HIV prevalence or core HIV prevention, testing, and treatment indicators. In addition, there is a need to strengthen situation analysis from national to community levels, including better contextual and qualitative data to inform the design of interventions; strategic, operational, and micro-planning; and implementation research. There is also a lack of data on the effectiveness and cost-effectiveness of interventions. A stronger evidence base would have a significant impact on a project's ability to do target-setting, planning, costing, implementation, and monitoring.
- 3. Make the case for sustained investments in KP programs.** LINKAGES has demonstrated that working closely with national and sub-national governments can have a positive and wide-ranging impact on acceptance and implementation of HIV-related activities for KPs. However, in most countries, support for KP programs is not well-established and may, therefore, be reduced or eliminated subject to changing social, political, and budgetary factors. In addition, KP programs are not delivered at scale and few countries have plans or funds in place to take them to scale. In the foreseeable future, sustainable HIV responses for KPs will depend on financing from domestic and international sources to fund programs and services. The challenge will be to ensure sufficient

national funds are allocated; addressing this challenge will require ongoing engagement with governments as well as robust evidence-based advocacy. There is a need for a clear “business case,” which recognizes the role of KP programs in achieving HIV epidemic control.

4. Re-energize efforts to reduce HIV-related and KP-focused stigma and discrimination.

Despite decades of work, levels of HIV-related stigma and discrimination remain high and, in many countries, KPs face additional societal stigma and discrimination. These forms of stigma and discrimination are one of the main barriers to uptake of HIV testing, linkage to care, and adherence to treatment among KPs and, consequently, undermine each stage of the HIV cascade of care. Focusing on reducing stigmatizing and discriminatory attitudes among health care workers is an important first step, but it will not address the impact of wider stigma and discrimination on the cascade or its contribution to violence and other human rights violations. From a development perspective, reducing stigma and discrimination should be a priority because of the multiple and positive effects it has on KP communities and the HIV response.

5. Accelerate the use of lessons and best practices. LINKAGES is beginning to generate evidence about effective approaches and interventions, particularly within individual country contexts and with specific KP communities. Now that LINKAGES has more implementation experience and data of publishable quality, it plans to place increased emphasis on publishing experience, lessons, and data in the peer-reviewed literature in order to contribute to the evidence base for KP programs. LINKAGES’ experience to date suggests that the following lessons or best practices can contribute to effective HIV programming for KPs in the future:

- Analysis and use of data for targeting, planning, implementing, and monitoring activities
- Dynamic micro-planning
- Strong and participatory partnerships with civil society and KP-led organizations; partnerships between these organizations and government health services
- Use of EPM/EPOA to gain better access to networks of KPs
- Combination of physical site and virtual approaches, including index testing, to improve reach and case finding
- Use of technologies and approaches that facilitate community-based HIV prevention and testing (i.e., PrEP, oral fluid testing, self-testing)
- Use of PNs and community-based ART to improve uptake of testing, ART initiation, and retention on treatment
- Appropriate support and incentives for PNs and PEs as well as an optimal ratio of different types of outreach workers
- Technical and organizational capacity development for civil society and KP-led implementing partners

V. RECOMMENDATIONS

There are two overarching recommendations relevant to “course correction” at this point in the LINKAGES project. These recommendations, and their specific sub-recommendations, center around improving project performance and achieving results, and the longer-term impact of the project, specifically sustainable HIV programming for KPs.

Improve project performance across the cascade

- 1) **Intensify efforts to reach or exceed PEPFAR targets at the country level.** In contexts where the targets are not attainable or where they are too easily reached, LINKAGES should collect, analyze, and present data to explain why and to show how the targets should be adjusted to reflect realities on the ground and available resources. LINKAGES may also need to work with PEPFAR/USAID to refine the target setting approach.
- 2) **Shift the balance of project resources to frontline work.** Improving performance will require LINKAGES management to focus project resources on direct implementation at the field level. Currently, allocation of resources to frontline work varies between countries; LINKAGES should analyze current allocations in project countries and take steps to shift the balance as appropriate. Greater investment in and support for frontline work is also critical to ensure implementation at sufficient scale to demonstrate impact.
- 3) **Strengthen analysis and use of data to enhance planning and targeting of interventions.** LINKAGES needs to do more to ensure that consistent and iterative micro-planning is conducted in all project countries to generate better data and analysis on the evolving local situation, including population size estimates, to inform strategic and operational planning. Quick but effective methods, such as the site walk approach used in Malawi, should be applied across project countries. More accurate population size estimates will also enable the project to set more accurate targets and to better monitor coverage. Integrating basic, widely proven, and widely accepted QI practices, such as Plan-Do-Study-Act, with micro-planning exercises could be an efficient and cost-effective way to reduce the leaks in the cascade. Partners also need to better understand why there are leaks in the cascade in order to refine and adapt their approach, and LINKAGES needs to intensify support to strengthen analysis and use of data to inform planning and QI. In addition, more attention needs to be given to operations/implementation research to generate contextual data, including qualitative data, which can improve understanding of the “why” of what is happening and the “how” of making improvements. Better analysis and use of data could be useful in other areas as well, including a better understanding of how different activities relate to one another (e.g., violence prevention and HIV testing uptake).
- 4) **Extend the application of effective approaches to improve performance across the cascade.** LINKAGES should move quickly to implement or expand EPM/EPOA across all project countries, given its demonstrated ability to increase reach, uptake of HIV testing, and HIV case detection. The value of peer navigation to improve performance across the cascade has also been shown in a number of LINKAGES countries; consequently, further evolution, expansion, and documentation of this approach should be a priority, particularly the role of PNs as “case managers” for clients who need additional support to start and stay on treatment. The experience of LINKAGES PNs as case managers is also highly relevant in generalized HIV epidemics as ART retention and viral suppression (i.e., the third 90) become increasingly important.

- 5) **Intensify efforts to reach higher risk, hidden sub-populations and give greater priority to underserved KPs.** Use of EPM/EPOA will be especially critical in reaching higher risk and hidden sub-populations, in addition to strengthening micro-planning. Reaching higher risk and hidden sub-populations will also require a better understanding of the nature and behaviors of these sub-populations. The evaluation team supports LINKAGES' plans to make more effective use of social media, index case finding, and other strategies to improve reach and case finding. LINKAGES should also give higher priority to KPs whose needs have not been well addressed to date. Although the relevant populations will depend on the given country and available funding, there are gaps in activities for TG, MSM, and PWID populations in many LINKAGES countries.
- 6) **Strengthen support for PNs and PEs.** LINKAGES needs to take a more strategic approach to PN mentorship, support, and career progression and remuneration to improve motivation and retention. Although the number and role of PEs may be reduced with increased use of EPM/EPOA, similar consideration should be given to motivation, retention, and remuneration of these individuals; if EPM/EPOA does reduce the need for PEs, there may be an opportunity to equip the remaining ones with additional skills. LINKAGES should also review strategies to ensure the safety and security of PEs and PNs, including alternative and more discreet approaches to bulky paper-based job aids and data collection tools.
- 7) **Strengthen the evidence base on context-specific models of service delivery for KPs.** LINKAGES should start to document: a) what mix of approaches to service delivery is the most effective and why; b) what will have the most impact in the short term; and c) what will be sustainable in the long term in different country contexts and for different KPs. For example, it is important to understand who currently accesses services from outreach clinical services, DICs, and static clinics and why they go to the different facilities. It is also important to understand what constitutes a practical and effective balance of stand-alone services and referral to public health facilities in different contexts. This will help to improve performance as well as to inform planning and costing for scale-up.
- 8) **Build on opportunities to improve access to STI services in order to increase HIV case finding.** LINKAGES is well placed to test and validate approaches to increase HIV case finding by providing better access to STI services that are appropriate in different country and health service contexts and for different KPs, and in settings where there are reliable supplies of STI drugs. For example, the pilot use of comprehensive STI testing by LINKAGES/Angola generated a significantly higher HIV testing yield among MSM and TG individuals than other LINKAGES activities targeting these populations. In some countries, approaches might include comprehensive STI clinical services in DICs (e.g., testing and treatment) while in others, it may be more feasible and sustainable to strengthen linkages to KP-friendly STI services, using PNs, for example, to facilitate client referrals. An additional benefit of improving access to STI testing and treatment, which is being explored by LINKAGES/Thailand, is its impact on PrEP uptake and efficacy. Leveraging experience across LINKAGES countries about the link between STI services and HIV case detection and access to other HIV services would be useful.
- 9) **Enhance cross-organizational and cross-country learning.** Effective approaches to cross-organizational learning employed in some countries should be adopted across the project. LINKAGES should also consider increasing the use of direct learning and sharing of practical experience through cross-organizational mentoring within countries and cross-country learning between country teams and implementing partners.

Contribute to sustainable KP programming

10) Demonstrate the effectiveness and cost-effectiveness of the LINKAGES model.

LINKAGES needs to generate evidence about the effectiveness and cost-effectiveness of its approach to HIV prevention, testing, and treatment among KPs, through its M&E activities and, where appropriate, special studies and practical, low-cost implementation research. Demonstrating impact and feasibility are critical to support advocacy with governments and other partners for increased investment in and national scale-up of HIV services and structural interventions for key populations.

11) Use LINKAGES' comparative advantage to generate increased country commitment to KP programming.

Given the time-limited nature of the project, LINKAGES country teams should initiate or accelerate dialogue and supporting analysis with government and other partners on scale-up, financing, and sustainability of HIV services for KPs. LINKAGES can capitalize on its good reputation and relationships with governments to advocate for increased domestic commitment and to broker partnerships between government and KP organizations. Action to strengthen advocacy should also be part of capacity building work with local implementing partners, in particular KP-led organizations, to ensure that these organizations have the skills required to sustain advocacy efforts after the end of the project.

12) Support wider and more rapid adoption of innovative approaches and emerging interventions.

Based on its country involvement in introducing and providing technical support for innovative approaches such as OraQuick, self-testing, and PrEP, LINKAGES is well placed to advocate with government partners for the policy changes required to support wider implementation of these approaches. LINKAGES should also leverage the extensive international evidence base for key innovations to support their advocacy efforts.

13) Give higher priority to building local partner capacity.

LINKAGES should shift from the creation and provision of guidance, tools, and training for local implementing partners to the provision of active and ongoing support of implementation by these partners, including the practical application of existing guidance and tools. In addition, sustained efforts are needed, particularly for KP-led partners, to continue to build the leadership, organizational and technical knowledge, and skills required to maintain KP engagement in national HIV responses. This should include the capacity for short- and long-term financial planning and meaningful participation in national dialogue on HIV financing.

14) Give higher priority to structural interventions.

Tackling structural barriers to access and uptake of HIV services and behavior change is central to effective KP programming. As with HIV service delivery, LINKAGES needs to support implementation of interventions to address stigma, discrimination, and violence at sufficient scale to demonstrate impact and generate evidence for advocacy. With respect to current project interventions, greater efforts should be made, not only by LINKAGES but also by governments and USAID, to ensure adequate coverage of training for health workers to reduce stigma and discrimination in health facilities in project catchment areas, and to strengthen client feedback and accountability mechanisms to support monitoring of the impact of training. VPR interventions need to pay more attention to violence prevention and access to legal support, as well as to be implemented at sufficient scale to demonstrate they are effective and efficient. Again, implementation at sufficient scale is likely to require additional resources and greater buy-in from government and donors.

- 15) **Leverage partnerships to address wider KP needs and structural barriers.** In countries where other partners are working with KPs or related issues, LINKAGES could do more to leverage the work of other programs to address the full range of issues that concern KPs and influence their HIV vulnerability and HIV service uptake. These issues include widespread societal stigma and discrimination, harmful gender norms, sensitization of the judiciary, work on human rights and criminalization, availability of drug and alcohol treatment, and economic empowerment.
- 16) **Strengthen monitoring and reporting.** At country level, LINKAGES should continue to strengthen the M&E capacity of local implementing partners and build on efforts to harmonize and consolidate data streams and reporting systems. LINKAGES should also expand and accelerate efforts to make datasets more useful and useable in real time by the people working at the frontline of the response. In addition, LINKAGES should continue working with government health services to improve tracking of clients across the cascade. At global level, LINKAGES needs to enhance the usefulness of country and global progress reporting and, in particular, to take immediate steps to improve the quality and consistency of data – and the presentation of data – in project reports. LINKAGES should also critically assess the value of the custom indicators to determine their added value, particularly in light of the reporting burden on implementing partner and country teams.
- 17) **Improve follow-up and documentation of project experiences and lessons.** LINKAGES needs to ensure the effectiveness of project activities is monitored, assessed, and documented, including the HIV prevention activities and structural interventions that can be more challenging to track and analyze. In addition, LINKAGES is generating a range of important lessons about promising practices – OraQuick, EPM/EPOA, PNs as case managers, VPR community networks, partnerships between DICs and public health facilities, collaboration with the police – and these should be documented in practical and cost-effective ways that make them useful to interested parties within and outside the project.

ANNEX I. SCOPE OF WORK

Assignment #: 434 [assigned by GH Pro]

Global Health Program Cycle Improvement Project (GH Pro) Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

Date of Submission: 7-5-2017

Last update: 2-1-2018

Amendment #2

I. TITLE: Evaluation of Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) Project

II. Requester / Client

☒ USAID/Washington

Office/Division: USAID Global Health Bureau / Office of HIV/AIDS / Priority Populations, Integration, and Rights Division (62.50%)

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

☒ 3.1.1 HIV

GH/OHA (62.50%)

☐ 3.1.2 TB

☐ 3.1.3 Malaria

☐ 3.1.4 PIOET

☐ 3.1.5 Other public health threats

☐ 3.1.6 MCH

☐ 3.1.7 FP/RH

☐ 3.1.8 WSSH

☐ 3.1.9 Nutrition

☒ 3.2.0 Other (specify):
USAID/RDMA (16.67%)
USAID/Angola (20.83%)

IV. Cost Estimate: _____ (Note: GH Pro will provide a cost estimate based on this SOW)

V. Performance Period

Expected Start Date (on or about): September 11, 2017

Anticipated End Date (on or about): June 30, 2018

VI. Location(s) of Assignment: (Indicate where work will be performed)

- Washington, D.C.
- 6 countries: Malawi, Kenya, Thailand, Laos, Angola, and Haiti. Criteria for country selection:
 - Model for support-technical assistance compared to service delivery
 - Countries included in LINKAGES' Acceleration Strategy
 - Availability of results and MER data over time, to determine outcomes
 - Size of the country buy-in to LINKAGES
 - Size of the targets in countries would demonstrate scale
 - Plans for costing study in country would provide additional funding

- Ongoing data collection and analysis in country

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

☒ **Performance Evaluation** (Check timing of data collection)

☒ Midterm ☐ Endline ☐ Other (specify):

Performance evaluations encompass a broad range of evaluation methods. They often incorporate before–after comparisons but generally lack a rigorously defined counterfactual. Performance evaluations may address descriptive, normative, and/or cause-and-effect questions. They may focus on what a particular project or program has achieved (at any point during or after implementation); how it was implemented; how it was perceived and valued; and other questions that are pertinent to design, management, and operational decision making

☐ **Impact Evaluation** (Check timing(s) of data collection)

☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention. They are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

☐ **Assessment**

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ **Costing and/or Economic Analysis**

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ **Other Analytic Activity (Specify)**

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR-funded, check the box for type of evaluation

☒ **Process Evaluation** (Check timing of data collection)

☒ Midterm ☐ Endline ☐ Other (specify):

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Impact Evaluation** (Check timing(s) of data collection)

☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

☐ **Economic Evaluation (PEPFAR)**

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

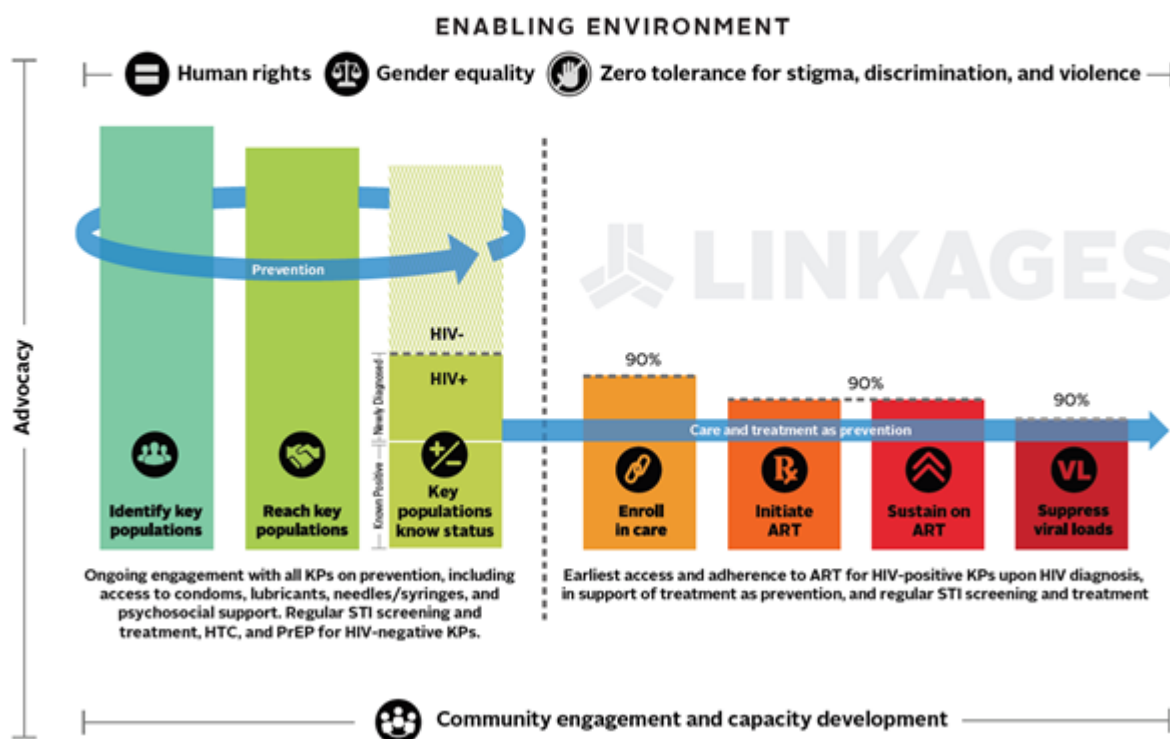
VIII. BACKGROUND

If an evaluation, Project/Program being evaluated:

Project/Activity Title:	Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) Project
Award/Contract Number:	Cooperative Agreement AID-OAA-A-14-00045
Award/Contract Dates:	June 11, 2014 – June 10, 2019
Project/Activity Funding:	\$225,000,000
Implementing Organization(s):	FHI 360
Project/Activity AOR/COR:	Judy Chen

Background of project/program/intervention (Provide a brief background on the country and/or sector context; specific problem or opportunity the intervention addresses; and the development hypothesis)

LINKAGES is a five-year cooperative agreement funded by the U.S. Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR) and implemented by FHI 360 in partnership with Pact, IntraHealth International, and the University of North Carolina at Chapel Hill. In line with USAID's goal, LINKAGES is accelerating the ability of governments, key population organizations, and private-sector providers to collaboratively plan, deliver, and optimize services that reduce HIV transmission among key populations (KPs) and extend life for those who are living with HIV. LINKAGES uses a newly revised HIV Services Cascade (Figure 1) as the strategic framework for the project. The HIV cascade illustrates the continuum of HIV prevention-care-treatment services to reduce HIV transmission as well as to ensure a high quality of life for KPs living with HIV. For those who are living with HIV, the cascade emphasizes the intervention stages of "reach, test, treat, and retain" as key steps to ensure long-term adherence to antiretroviral therapy (ART), which results in suppressed viral load and enhanced quality of life. For all people, the HIV cascade stresses the importance of prevention (primary or secondary), namely, the promotion of health-seeking behaviors, including consistent condom use, regular and repeated HIV testing for those who are uninfected, and more proactive engagement with the health sector. LINKAGES aims to ensure that both HIV-negative and HIV-positive KPs consistently engage in prevention interventions.



The HIV cascade and the enhanced use of programmatic data associated with the cascade can be used to:

1. Identify leaks in the system where KPs are unable to access critical services in the comprehensive package
2. Identify where KPs are lost to follow-up
3. Analyze the root causes of those gaps
4. Identify the most effective solutions to improve health service delivery
5. Refine and focus interventions and services to ultimately reduce HIV transmission and maximize impact

LINKAGES engages U.S. government (USG) partners, local and international organizations, and civil society organizations (CSOs), including KP-constituency-led organizations, to jointly plan, implement, and evaluate project interventions that are tailored to local KP needs. In particular, the LINKAGES capacity-strengthening approach fosters country leadership and emphasizes learning by doing, and in-country counterpart and south-to-south (S2S) mentoring.

This HIV prevention, care, and treatment cascade is not complete without acknowledging the role of structural barriers and the need for a supportive environment along this continuum to achieve viral suppression among people living with HIV (PLHIV). Structural barriers experienced by KPs include experiences of stigma or discrimination related to a person's identity or behavior; regressive laws and policies that undermine public health responses; violence, including gender-based violence (GBV); and a range of human rights abuses. These and other challenges faced by KPs exacerbate HIV risk, prevent access to life-saving HIV prevention or treatment services, and result in a leaky cascade where PLHIV

continue to drop out of care. While changing laws and policies may take time, a range of community mobilization and engagement approaches to mitigate the negative impact of these barriers has proven effective. Addressing structural barriers is now increasingly acknowledged by major global health experts and researchers as necessary and central to an effective HIV response.

LINKAGES is guided by the following principles, which are intrinsic to all of its strategies, approaches, and activities.

- **Engage and empower.** LINKAGES engages and empowers key populations throughout its programming. LINKAGES works in partnership with KP communities and through KP-led organizations and allies.
- **One size does not fit all.** LINKAGES understands that KPs are individuals with different needs and preferences. LINKAGES will build choice into its country-level implementation, allowing for different models of service delivery in different contexts (as well as a mix of models in any one context). Also, global tools will be designed to allow for flexibility and easy adaptation at the country level. New technologies, approaches, and innovations for the purpose of expanding prevention, testing, care, and treatment options will be highlighted and prioritized.
- **Structural barriers remain paramount.** LINKAGES understands that structural interventions — particularly stigma reduction, violence prevention, and response — are essential for closing gaps in the HIV cascade for KPs.
- **Data are essential for programming.** LINKAGES supports the collection and use of data at all levels to inform and improve programming in real time.

LINKAGES is a partnership among FHI 360, IntraHealth International, University of North Carolina at Chapel Hill, and Pact. But the project is also strengthened by guidance provided by the LINKAGES Advisory Board (LAB), which comprises representatives of global KP networks and international KP allies. At the country level, LINKAGES is a partnership of projects, host-country government ministries, KP-led organizations, and allies who work together to effectively serve the HIV and other health-related needs of individuals and communities. LINKAGES has in place numerous sub-awards and memoranda of understandings (MOUs) with international organizations and global KP networks to provide technical support globally and S2S mentoring in the field. In this work plan, when referring to “LINKAGES,” we are referring to the entire LINKAGES team, which is supported by these broad partnerships.

LINKAGES has established a global acceleration initiative that leverages existing partnerships in order to accelerate and strengthen delivery of a comprehensive package of health services for KPs at scale. Under this initiative, *acceleration* means simultaneously delivering speed, scale, and standards (a common core program). In order to rapidly scale up KP programming at the site level in LINKAGES buy-in countries, LINKAGES established program acceleration teams to diminish bottlenecks and provide frequent and rapid technical assistance (TA) to country-level programs across the cascade to reach 90/90/90 for KPs.

In FY16, LINKAGES developed the *LINKAGES Key Population Program Implementation Guide* (acceleration guide), which is in line with global KP guidance for the different populations. The guide serves as a common core program for LINKAGES countries, and countries in Africa and the Caribbean were oriented and trained on the components of the guide in FY16. These country teams then drafted comprehensive country acceleration plans that outline when key program areas would be implemented in their respective countries and note any TA required. Technical assistance providers were also oriented to LINKAGES, acceleration, the acceleration guide, and other

LINKAGES tools through the regional acceleration workshops and were matched with countries. During the workshops, TA providers supported countries in developing their acceleration plans.

In FY17, intensive acceleration TA will continue to be provided by LINKAGES technical experts, consultants from the University of Manitoba, and other LINKAGES global consultants. Technical assistance will continue to be provided according to the *LINKAGES Key Population Program Implementation Guide*. All TA providers will have extensive KP experience and will be content experts in the areas outlined in the guide. They will focus on supporting countries in conducting micro-planning based on hot spot mapping/size estimation, establishing drop-in centers (DICs) and community committees, linking HIV-positive KP members to care, developing strategies for rolling out and improving test and start for KPs, and retaining KPs in care. These TA providers will work closely with LINKAGES country teams to ensure that technical interventions are operationalized in a way that takes into account country programs' existing structures and levels of operation.

To ensure a comprehensive, targeted, and consistent TA approach, TA providers will continue to be assigned to specific countries, spending time getting to know the country contexts and teams. Technical assistance will be provided by teams of experts representing the full array of technical areas. Each country will receive support from a TA team that includes at a minimum a clinical expert, a programmatic monitoring expert, and a community/structural intervention expert. Additional TA will be added as needed.

Standard checklists will also be developed to guide TA provision at the site level and will be linked to quality assurance/quality improvement (QA/QI) indicators. See the crosscutting section for more information.

In addition to the in-country targeted TA, acceleration community of practice meetings will be held at the regional level (one for Africa and one for Latin America and the Caribbean [LAC]) in FY17 in order to consolidate and share learning across countries. Countries participating in these workshops are Kenya, Malawi, Haiti, Democratic Republic of the Congo (DRC), Cote D'Ivoire, South Sudan, Botswana, Mozambique, Angola, Cameroon, Barbados, Bahamas, Trinidad and Tobago, Jamaica, Burundi, and Swaziland.

Core funding for acceleration will supplement any field support funding for acceleration TA to ensure that countries are receiving enough support to substantially accelerate and scale programming at the country level in line with the demands of increased PEPFAR targets.

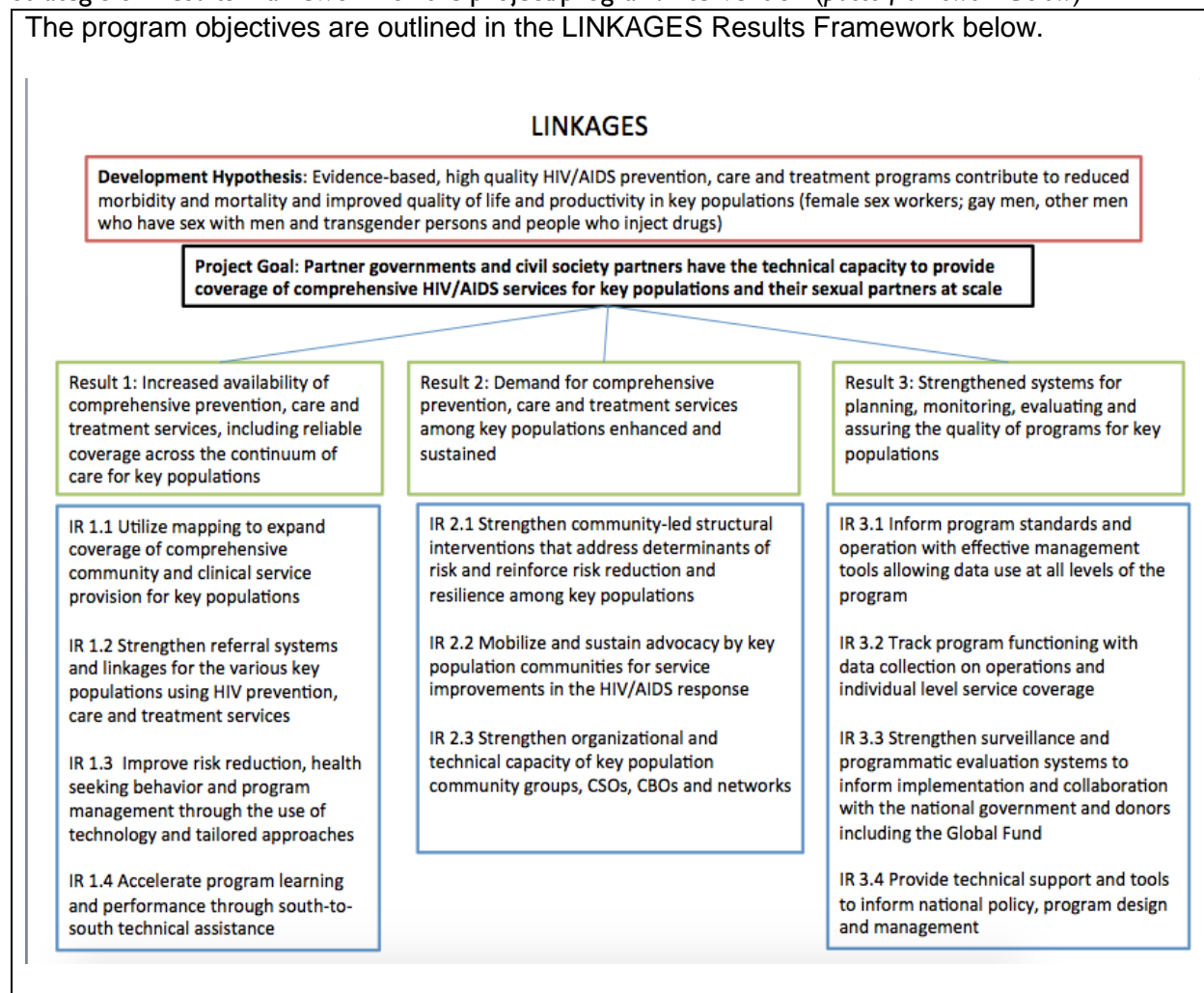
Since it was awarded in June 2014, LINKAGES has been the primary USAID/Washington central mechanism through which the Bureau for Global Health has funded KP programming through the President's Emergency Plan for AIDS Relief (PEPFAR) including sensitive and strengthened service delivery across the HIV cascade of prevention, treatment and care, outreaching to KPs in order to build demand for services, strengthening advocacy capacity of local civil service organizations (CSOs), and working to build an enabling environment in healthcare settings and in larger social contexts. Being the first ever PEPFAR/USAID-funded mechanism solely devoted to addressing the HIV among KPs, with a team of KP experts and numerous regional and local KP-organizational partners, LINKAGES is uniquely positioned and qualified to provide comprehensive HIV prevention, treatment and care services for KP, as well as meet the unmet demand from country buy-ins. For decades, often as a result of extreme stigma and discrimination, KP-specific HIV programming, especially in generalized epidemics, was not recognized as an important component of a comprehensive plan to address HIV. However, through research, data analysis, and advocacy, it is now recognized that addressing KP issues directly is vital to achieving the globally accepted UNAIDS 90-90-90 strategy of working towards an AIDS Free

Generation; or by 2020, 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy will have viral suppression. PEPFAR is the largest external funder of HIV programs globally and the largest funder of key populations programs globally. LINKAGES is the only central mechanism addressing key populations in PEPFAR. With the approval of this increase, the LINKAGES project will determine, more than any other mechanism funded by any donor, whether 90-90-90 is achieved globally among the populations with the most disproportionate burden of HIV and the widest gap today in access to HIV services.

Theory of Change of target project/program/intervention

Strategic or Results Framework for the project/program/intervention (paste framework below)

The program objectives are outlined in the LINKAGES Results Framework below.



What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Geographic coverage is global, including 30 countries that have LINKAGES programming. The target groups for the activity include sex workers (SWs), men who have sex with men (MSM), transgender individuals (TG) and people who inject drugs (PWID).

IX. Purpose, Audience & Application

- A. **Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)?
Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The main purpose of the performance evaluation is to:

- 1) Assess the effectiveness, efficiency and quality of the LINKAGES activity at the national, provincial, facility, and community-based service levels; identify implementation gaps/challenges; determine how well the project is achieving its goals, objectives, and performance targets/results.
- 2) Propose key recommendations for improvement and direction for the remaining activity period.
- 3) To document lessons learned and provide recommendations that will inform future programming directions for USAID's key populations HIV support.

- B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

- USAID Key Populations and Rights Branch
- OHA Leadership
- USAID Missions with Key Populations programming
- LINKAGES Project staff (FHI360 and partners)

- C. **Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

- Findings and recommendations from this performance evaluation will be used for further improvement and direction for the remaining activity period.
- Conclusions from this evaluation will assist USAID in shaping the direction of future project(s).

X. Evaluation/Analytic Questions & Matrix:

- Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID Evaluation Policy** recommends **1 to 5 evaluation questions**.
- State the method and/or data source and describe the data elements needed to answer the evaluation questions

	Evaluation Question	Evaluation Methods	Application or Data Use
1.	How effective is the project in achieving its goals, objectives, and performance targets?	<ul style="list-style-type: none">• Document & data review• Key informant interviews• Secondary data analysis• Focus Group Discussions• Survey	<ul style="list-style-type: none">• Feedback for course correction• Recommendations for future project(s)
2	What are the project's strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?	<ul style="list-style-type: none">• Document & data review• Key informant interviews• Secondary data analysis• Focus Group Discussions• Survey	<ul style="list-style-type: none">• Feedback for course correction• Recommendations for future project(s)

	Evaluation Question	Evaluation Methods	Application or Data Use
3	What are the constraints to successful implementation of this program?	<ul style="list-style-type: none"> • Document & data review • Key informant interviews • Secondary data analysis • Survey 	<ul style="list-style-type: none"> • Feedback for course correction • Recommendations for future project(s)
4	How well does the project align with PEPFAR and OHA and global priorities and approaches?	<ul style="list-style-type: none"> • Document & data review • Key informant interviews • Survey 	<ul style="list-style-type: none"> • Feedback for course correction • Recommendations for future project(s)
5	Is there a need for a global follow on KP mechanism?		
<p>At the conclusion of the evaluation, it is expected that the following recommendations will be provided to USAID/Washington Key Populations Team:</p> <ol style="list-style-type: none"> 1) Recommendations to build on strengths, correct weaknesses and improve implementation to enable USAID and implementing partner staff to develop a course of action for the remainder of the project. 2) Recommendations for best practices in Key Populations programming to address the epidemic that can be integrated into future programming. 			

Other Questions [OPTIONAL]

(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation or analysis.)

Additional Questions for Thailand:

Program management:

1. What are enabling factors supporting the implementation of PEPFAR Incentive Fund (PIF) and barriers undermining its success?

Program accomplishments/results:

2. To what extent and how have the PIF activities been implemented to support institutionalization of domestic financing systems?
 - a. What progress has been made to support the financing of community-based services? In particular, this should be focused on the following:
 - i. Implementation of and capacity building support for community-led HIV services, including HIV prevention, testing and treatment services;
 - ii. Strategies and systems to sustain financing for community-led HIV services including HIV prevention, testing and treatment services.

Additional Questions for Angola:

1. In FY2015 LINKAGES started working with two CBOs (ASCAM and CAJ/IRIS), in FY16 scaled up to five CBOs (ASCAM, CI, ABC, FOJASSIDA, MWENHO), and in FY17 has scaled back to three CBOs (ASCAM, CI, MWENHO). What are some of the lessons learned, and how have they led to changes in implementation strategies and practices?
2. To what extent have LINKAGES CBOs been able to cover all geographical priority areas (10 community sites) in Luanda province with prevention and testing services?
3. To what extent is the peer navigator to beneficiary ratio rational in order to reach targets, and continue to follow KP clients along the cascade?
4. What progress has been made by LINKAGES to improve linkage between community and PEPFAR-supported health facilities, strengthen KP-friendly services, and what are the lessons learned?

5. To what extent are LINKAGES methodologies, interventions, and management setting the stage for the future sustainability, replication, adaptation, and adoption of project outputs and outcomes?

XI. Methods:

Check and describe the recommended methods for this analytic activity. Selection of methods should be **aligned with the evaluation/analytic questions** and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

General Comments related to Methods:

This evaluation will collect information about the implementation of LINKAGES to date, in providing quality and comprehensive HIV/AIDS prevention, care and treatment services, establishing linkages and referrals between provincial, facility and community services, technical assistance to local and national partners, and challenges. This performance evaluation will assess the contribution of FHI360's global leadership in key populations, and ability to scale up its technical assistance in countries to improve the quality of HIV/AIDS prevention, care/support and treatment services, alongside the clinical cascade, at the health center and community levels and capacity building at the national and provincial levels. Whenever possible, the evaluation should mention gaps in programming as well as innovations and successes, both of which could inform the design future project(s). The evaluation will also consider LINKAGES' contributions to global technical leadership, including work with technical advisory groups, stakeholders, multilaterals, and also presence at conferences, publications, and technical fora.

Data Quality

The qualitative and quantitative data used in this evaluation should meet the following five data quality standards in accordance to USAID's Automated Directive System (ADS) 203: 1) Validity; 2) Integrity; 3) Precision; 4) Reliability; and 5) Timeliness.

Limitations

This is a performance evaluation conducted prior to the conclusion of a USAID-funded project; it is not intended to be a rigorous quasi-experimental or experimental design outcome or impact evaluation with predetermined counterfactual groups. It does not attempt to attribute change in health outcome or impact to the project itself.

Document and Data Review *(list of documents and data recommended for review)*

This desk review will be used to provide background information on the project, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

- LINKAGES Cooperative Agreement, including modification documents
- Annual Reports
- Quarterly Reports
- Information about initial country scoping visits as the project started up.
- Headquarters and country level work plans, and sub-agreements as appropriate
- LINKAGES monitoring and other internal reports
- LINKAGES Monitoring and Evaluation data
- Joint HIV Cascade Assessments
- National HIV/AIDS Strategy for specific countries to be included in the assessment
- UNAIDS Atlas
- PEPFAR 3.0 "Controlling the Epidemic: Delivering on the Promise of an AIDS-free

Generation”

- Other relevant documents that may assist the evaluators, such as the Concept Note that was submitted to the Global Fund in November 2014
- Other sources, as needed

LINKAGES has built a global database that includes key indicators from each country in which it works, and the evaluation team will have access to this data. In addition, other data sources should be used, as appropriate, at the country level, to include:

- HIV, STI, and behavioral surveillance data (PLACE, IBBS, DHS HIV data, PHIA, etc.)
- Project level formative & evaluation research
- Monthly program reports and quarterly narrative reports from Implementing Agencies (IAs)
- Quality assurance surveys
- Government/donor/CA program data (upstream indicators)
- UNAIDS 2014 GARPR report and other recent UN reports on PNG and HIV
- Monthly reporting of patient records from IAs with clinical services
- Performance evaluation data
- STI clinic data
- Relevant KP SIMS data
- Other sources, as needed

■ **Secondary analysis of existing data** *(This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses)*

A thorough review of existing data, and descriptive statistical analysis (including the construction of the clinical cascade from FHI360 program data), with the possibility for more advanced statistical analysis, of existing quantitative data will also be conducted. Possible datasets for re-analysis are listed below.

Data Source (existing dataset)	Description of data	Recommended analysis
LINKAGES project monitoring data routinely collected by FHI360	Data routinely collected as part of the project, primarily for indicator reporting and management purposes.	<ul style="list-style-type: none"> • Comparison of results against targets. • Crosstabulation by type of key populations • Confirm findings as reported in Quarterly and Annual reports. • Trends over time since the beginning of the project • Cross tabulations of key indicators by key demographics (e.g., location, sex, age)

■ **Key Informant Interviews** *(list categories of key informants, and purpose of inquiry)*

Interviews will be conducted using a semi-structured question guide. Key informants will include, but not limited to:

- USAID/Washington staff working on Key Populations
- USAID/Mission staff working on LINKAGES
- Office of the Global AIDS Coordinator (OGAC) staff
- Center for Disease Control and Prevention (CDC) staff working on Key Populations
- FHI360 staff and sub-partners' staff, as appropriate
- Government representatives, as appropriate in country
- Beneficiaries (health center staff, SW, MSM, TG, PWID, etc.)

- Other donor and implementing partners (PSI, DFAT, GFATM, UNAIDS etc.)
- Discussions with representatives of CSOs, especially key population leaders and those who advocate for key populations.

■ **Focus Group Discussions** *(list categories of groups, and purpose of inquiry)*

The purpose of the focus group discussions (FGDs) are to investigate strengths, weaknesses, successes and challenges as seen by the beneficiaries of LINKAGES. The FGDs will be a semi-structured gathering of key population beneficiaries, service users, and others who may not utilize services in the country program but knows about services. The team members will take informal notes, without any audio recording device, and the notes will be collated and discussed with team members at the end of the day.

■ **Group Interviews** *(list categories of groups, and purpose of inquiry)*

The purpose is to cluster some Key Informants (see above) into groups for interviews so that information on programs can be shared in a team environment. Categories of groups could include KP and/or HIV teams at FHI360 field and headquarter offices and sub-grantee organizations including community and clinical service delivery sites. The Evaluation Team will be cognizant to avoid any power differentials within a group, to insure that all participants in a group feel comfortable sharing their opinions.

☐ **Client/Participant Satisfaction or Exit Interviews** *(list who is to be interviewed, and purpose of inquiry)*

■ **Survey** *(describe content of the survey and target responders, and purpose of inquiry)*

The purpose of the survey would be to obtain information from missions and LINKAGES teams in country. The questionnaire would be short and developed in collaboration with the evaluation team, as appropriate.

■ **Observations** *(list types of sites or activities to be observed, and purpose of inquiry)*

The purpose of observations is to observe LINKAGES project intervention activities using a semi-structured observation checklist during site visits. Sites include, but not limited to, drop-in centers, community and clinical service delivery sites, community-based ART distribution sites, public health sites, and others.

XII. HUMAN SUBJECT PROTECTION

The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. **Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB.** The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:

- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment

- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

XIII. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

The evaluation will:

1. Review information related to the relevant HIV/AIDS and health issues being addressed at the global, national, and community level, and determine the extent of current initiatives of FHI360 and the government (national and local), and their contribution to the overall national responses.
2. Analyze data within the context of PEPFAR initiatives (depending on country selection, initiatives may include DREAMS, Key Populations Challenge Fund, Key Populations Implementation Science, etc.), focus on the provision of technical assistance, capacity building and advocacy.
3. Ascertain program effectiveness in reaching key populations, retaining those HIV+ into care and treatment, and project impact on HIV acquisition and/or onward transmission
4. Assess the various current and potential areas for intervention, as described in the program implementation guide, capacity building of local implementing agencies and government counterparts, and violence and stigma reduction activities.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data behavior surveillance survey data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

XIV. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this analytic activity. These include LINKAGES award documents, global annual work plans, and country-specific workplans, as

appropriate, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (as available). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

In order to maximize efficiencies, Washington, D.C.-based data collection will begin after the TPM with local partners e.g. Office of the Global AIDS Coordinator, USAID, FHI360, and others as needed. CDC colleagues will be interviewed virtually.

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, at USAID/Washington headquarters, as well as individual in-country briefings with each country team included in the evaluation. These additional meetings will be determined in consultation with each Mission and coordinated with USAID/Washington. These briefings are:

- **Evaluation launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID/Washington**, as part of the TPM. At the beginning of the TPM, so the Evaluation Team and USAID can discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- **Workplan and methodology review briefing**. At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed.
- **In-brief with project headquarters** to review the evaluation plans and timeline, and for the implementing partner (FHI360) to give an overview of the project to the Evaluation Team.
- The Team Lead (TL) will **brief** USAID/Washington Key Populations Branch Chief **weekly** to discuss progress on the evaluation and any need for logistical support. As preliminary findings arise such as country level debriefs, the TL will share these during the routine briefing, and in an email.

- A **final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high-level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (*Note: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- **IP and Stakeholders' debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be deemed sensitive by USAID.
- **At the country level**, it is expected that the team will have **in-brief meetings with the USAID Mission and LINKAGES country teams**. At the end of the consultant's time in country, they should have a **debrief meeting to share preliminary findings with the country teams** and with the USAID/Washington team. The briefings and debriefings will be discussed further at the team planning meeting, prior to travel commencement.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

Evaluation/Analytic Report – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting.
2. The team lead will provide a separate internal USAID memo that provides information about management, the program, or other sensitive issues that will remain internal to USAID.
3. GH Pro will submit the draft report and the memo to USAID.
4. USAID/Washington will review the draft report and the memo. USAID country missions where the evaluation takes place, will also review the draft report, in a timely manner, and send their comments and edits back to USAID/Washington, who will consolidate and send back to GH Pro.
5. GH Pro will share USAID's comments and edits with the Team Lead, who will then update the memo and the draft report, complete final edits, as needed, and resubmit to GH Pro.
6. GH Pro will then share this report with LINKAGES to review the report and provide a statement of difference, if they choose.
7. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
8. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USAID separate from the Evaluation Report.

When feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.

XV. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under "Other" in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
■ Launch Call	September 2017 (<i>Exact date TBD</i>)
■ Attend TPM in Washington, D.C.	October 30 – November 3, 2017
■ Attend in-brief with USAID/Washington	October 30, 2017
■ Workplan briefing with USAID	November 3, 2017
■ Attend in-brief with LINKAGES	October 31, 2017
■ Submit workplan with timeline	November 2, 2017
■ Submit evaluation protocol with data collection tools	November 2, 2017
■ Routine briefings	Weekly
■ Conduct desk review	Prior to travel to DC, by October 27, 2017
■ Documentation of results from desk review	October 27, 2017
■ Present in-country in-brief / debriefs with USAID Missions with Power Point presentation	In-briefs – Upon arrival in country Debriefs – Prior to country departure On/about November 5 – January 31, 2018
■ Remote debrief with USAID mission teams with Power Point presentations (prior to draft report completion)	TBD, November 5 – January 31, 2018
■ Debrief with USAID/Washington with Power Point presentation	TBD, February, 2018
■ Debrief with FHI360/LINKAGES Washington, D.C. with Power Point presentation	TBD, February 2018
■ Draft report and management memo	<i>Submit to GH Pro: March 2018</i> <i>GH Pro submits to USAID: March, 2018</i>
■ USAID shares with country Draft Report team missions for comment	April, 2018
■ Final report	<i>Submit to GH Pro: April 2018</i> <i>GH Pro submits to USAID: April, 2018</i>
■ Raw data (to be uploaded into the DDL)	April, 2018
■ Dissemination activity	
■ Report Posted to the DEC	May, 2018
<input type="checkbox"/> Other (specify):	

Estimated USAID review time

Average number of business days USAID will need to review the Report? 15

Business days

XVI. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise.
- Note that **all team members will be required to provide a signed statement attesting that they have no conflict of interest (COI)**, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activity:

- *List desired qualifications for the team as a whole*
- *List the key staff needed for this analytic activity and their roles.*
- *Sample position descriptions are posted on USAID/GH Pro webpage*
- *Edit as needed GH Pro provided position descriptions*

Overall Team requirements:

Team Lead/Evaluation Specialist: This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead will have extensive experience conducting health project evaluations, including evaluation of HIV/AIDS projects. S/he will ensure quality assurance on evaluation issues, including design methods and the development of data collection instruments.

Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations.

Qualifications:

- Advanced degree in Public Health, Public Policy/Administration, or a related field
- Minimum of 10 years of experience in public health, which includes experience in implementation of health activities in resource limiting settings
- Demonstrated experience leading health sector project/performance evaluation/analytics, utilizing both quantitative and qualitative s methods
- Demonstrated ability in designing and implementing development programs on a nation-wide or region-wide basis.

- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management, leadership, teamwork and teambuilding
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience with key populations is desirable, including people who inject drugs.
- Familiarity with USAID and PEPFAR project implementation
- Familiarity with USAID and PEPFAR policies and practices
 - Evaluation policies
 - Results frameworks
 - Performance monitoring plans

Key Staff 1, 2 & 3 Title: Key Populations Specialist (FSW and for MSM/TG)

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in HIV, in prevention, treatment, care and support services, particularly for high risk groups. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:

- At least 8 years' experience with HIV/AIDS projects/programming; USAID project implementation experience preferred
- Expertise in supply and demand for HIV services at the community and clinical level
- Knowledgeable about HIV/AIDS prevention, clinical services, health systems strengthening, policy, and other issues related to targeted interventions for HIV service delivery for key populations
- Firm understanding of working with key populations, including dealing with stigma and discrimination
- Clinical experience would be considered a plus
- Familiar with PEPFAR guidelines and policies, including
 - PEPFAR Next Generation Indicators Reference Guidance
 - PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide
 - PEPFAR Evaluation Standards of Practice
 - Capacity Building and Strengthening Framework
 - Gender Strategy
 - Country Operational Plans (COP)
 - Site Improvement through Monitoring System (SIMS)
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 4 Title: Analyst (Evaluation Specialist)

Roles & Responsibilities: Serve as a member of the evaluation team, assist the lead evaluator in providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, ensuring highest level of reliability and

validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- Significant experience in developing and implementing monitoring systems and conducting evaluations for HIV/AIDS prevention and/or impact mitigation and service delivery programs
- An advanced degree in public health, evaluation or research or related field
- Proficient in English
- Good writing skills, including extensive report writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Familiarity with USAID and PEPFAR M&E policies and practices
 - Evaluation policies
 - Results frameworks
 - Performance monitoring plans
 - PEPFAR Next Generation Indicators Reference Guidance
 - PEPFAR Monitoring, Evaluation, and Reporting 2.0 Indicator Reference Guide
 - PEPFAR Evaluation Standards of Practice
 - Site Improvement through Monitoring System (SIMS)

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local **HIV Key Populations Specialist/Logistics (up to one for each country)**. The specialist will provide both technical knowledge and understanding of the HIV key populations context in each country visited by the evaluation team. The qualifications are the same as those listed for the KP specialists. In addition, s/he will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. The person will have technical knowledge, and a strong command of English. S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will

work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/he may also be asked to assist in translation of data collection tools and transcripts, if needed.

Local **Translators** will be contracted for Angola, Thailand, and Laos (**1 per country**)

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ Full member of the Evaluation Team (including planning, data collection, analysis and report development) – If yes, specify who:

☐ Significant Involvement anticipated – If yes, specify who:

☒ No: LINKAGES Management Team will be included as key informants.

Staffing Level of Effort (LOE) Matrix:

This LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

- a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
- b) Immediately below each staff title enter the anticipated number of people for each titled position.
- c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
- d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- e) At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of Effort in **days** for each Evaluation/Analytic Team member

Activity / Deliverable		Evaluation Team								
		Team Lead/ KP Spec (MSM) (D Hales)	Analyst (K. Attawell)	KP Specialist (FSW) (P Huygens)	KP Specialist (FSW) (A Bishop)	Thailand/ Laos KP Specialist (S. Sartsara)	Kenya KP Specialist (W. Owanda)	Angola KP Specialist (R. Moreira)	Malawi KP Specialist (K. Moyo)	Haiti KP Specialist (R. Cassagnol)
Number of persons →		1	1	1	1	1	1	1	1	1
1	Launch Briefing	0.5								
2	Desk review w/ documented results	6	12	6	6	5	5	5	5	5
3	Travel to DC	2		3	3					
4	In-brief with USAID/OHA	0.5		0.5	0.5					
5	Team Planning Meeting in DC	4		4	4					
6	Workplan briefing with USAID/OHA	0.5		0.5	0.5					
	In-brief with LINKAGES	0.5		0.5	0.5					
7	Data collection in DC									
8	Preparation for Team convening in-country	2		2	2	2	1	2	2	1
9	Travel to countries (from DC &/or home)	9.5		9	9					
10	Briefings (in & out) with Mission (6 countries)	3		3	3	1	1	1	1	1
11	In-brief with project (6 countries)	1.5		1.5	1.5	1	1	1	1	1
12	Prep / Logistics for in-country Site Visits (6 countries, 3 countries per key consultant)	2		2	2	2	1	2	2	1
13	Data collection / Country Visits (6) (including travel to sites)	27		27	27	15	8	10	9	5
14	Data analysis (remote & DC)	7	13	5	5	2	1	2	1	1
15	Travel to DC	1								
16	3 Debrief meetings with USAID/OHA with prep, 6 country-debriefs with prep	13		3	3					
17	IP & Stakeholder debrief workshop with prep	1		1	1					
18	Depart DC	1								
19	Draft report(s)	8	10	7	10	2	2	3	2	2
20	GH Pro Report QC Review & Formatting		3							
21	Submission of draft report(s) to Mission									
22	USAID Report Review									
23	Revise report(s) per USAID comments	3	2	2	4	1	1	1	2	1
24	Finalize and submit report to USAID									
25	Dissemination Activity	1								
26	508 Compliance Review									
27	Upload Eval Report(s) to the DEC									
	Total LOE	94	40	77	82	31	21	27	25	18

Note: Translator in Angola will work 12 days of LOE; Translator in Thailand, and Laos will work 14 days of LOE.

If overseas, is a 6-day workweek permitted

☒ Yes

☐ No

Travel anticipated: List international and local travel anticipated by what team members.

- Washington, DC
- 6 countries: Malawi, Kenya, Thailand, Laos, Angola, and Haiti

XVII. LOGISTICS

Visa Requirements

List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

GH Pro will provide supporting documents and reimbursement for visa applications and associated expenses.

Washington DC:

- No visa required for Australian, Netherlands, or Belgian citizens, but if GH Pro is expected to assist with other countries' visa applications while the consultants are in DC, it would be helpful if they first obtained a tourist visa.

Laos:

- Mission requires 30 days' notice and a diplomatic note before meetings can be scheduled with government counterparts.
- Visa required for US, Belgian, Netherlands, and Australian citizens

Thailand:

- Visa required for US, Belgian, and Netherlands citizens.

Haiti:

- No visa required.

Kenya:

- E-visa available for Belgian, US, Netherlands, and Australian citizens

Malawi:

- Visas should be obtained prior to arrival, but they can be obtained on arrival if the consultants have an authorization letter from the Government of Malawi. Consultants will obtain the visa prior to arrival, and will be granted a Visitor permit upon arrival, which is valid for 30 days.
- Visa required for US, Belgian, Netherlands, and Australian citizens

Angola:

- Visas take several weeks to process; GH Pro will use the visa facilitator for this process.
- Visa required for US, Belgian, Netherlands, and Australian citizens

List recommended/required type of Visa for entry into counties where consultant(s) will work

Name of Country	Type of Visa		
Washington, DC	<input checked="" type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference
Thailand	<input checked="" type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference
Laos	<input checked="" type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference
Angola	<input checked="" type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference
Kenya	<input checked="" type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference
Malawi	<input checked="" type="checkbox"/> Tourist	<input type="checkbox"/> Business	<input type="checkbox"/> No preference
Haiti	Visa not required		

Clearances & Other Requirements

Note: Most Evaluation/Analytic Teams arrange their own work space, often in conference rooms at their hotels. However, if a Security Clearance or Facility Access is preferred, GH Pro can submit an application for it on the consultant's behalf.

GH Pro can obtain **Facility Access (FA)** and transfer existing **Secret Security Clearance** for our consultants, but please note these requests, processed through AMS at USAID/GH (Washington, DC), can take 4-6 months to be granted. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. FAs for non-US citizens or Green Card holders must be obtained through the RSO. If FA or Security Clearance is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required prior to the consultant's travel, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS)**. HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required complete the one-week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&IE to take this course.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access (FA)
Specify who will require Facility Access: _____

☒ Electronic Country Clearance (ECC) (International travelers only)
☒ High Threat Security Overseas Seminar (HTSOS) (required in most countries with ECC)
☐ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)

☐ GH Pro workspace
Specify who will require workspace at GH Pro: _____

☒ Travel -other than posting (specify): Malawi, Kenya, Angola, Thailand, Laos, Haiti
☐ Other (specify): _____

Specify any country-specific **security concerns and/or requirements**

XVIII. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XIX. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities
<p>USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</p> <p>Before Field Work</p> <ul style="list-style-type: none"> • <u>SOW</u>. <ul style="list-style-type: none"> ○ Develop SOW. ○ Peer Review SOW ○ Respond to queries about the SOW and/or the assignment at large. • <u>Consultant Conflict of Interest (COI)</u>. To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates. • <u>Documents</u>. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment. • <u>Local Consultants</u>. Assist with identification of potential local consultants, including contact information. • <u>Site Visit Preparations</u>. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs. • <u>Lodgings and Travel</u>. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation). <p>During Field Work</p> <ul style="list-style-type: none"> • <u>Mission Point of Contact</u>. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work. • <u>Meeting Space</u>. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space). • <u>Meeting Arrangements</u>. Assist the team in arranging and coordinating meetings with stakeholders. • <u>Facilitate Contact with Implementing Partners</u>. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings. <p>After Field Work</p> <ul style="list-style-type: none"> • <u>Timely Reviews</u>. Provide timely review of draft/final reports and approval of deliverables.

XX. ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See [How-To Note: Preparing Evaluation Reports](#))

The product of this evaluation will be a final report that evaluates the successes, shortcomings, and lessons learned of FHI360's LINKAGES activities that will inform a new project design for USAID. The report should also include an evaluation of the sustainability of the project. The report should include recommendations for improving USAID's assistance delivery for key populations and highlight comparative advantages in areas not addressed by other initiatives.

The **Evaluation/Analytic Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the [USAID Evaluation Policy](#)).

- The report should not exceed **30 pages** (excluding executive summary, table of contents, acronym list and annexes).
- The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).
- Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

USAID Criteria to Ensure the Quality of the Evaluation Report (USAID ADS 201):

- Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.
- Evaluation methodology should be explained in detail and sources of information properly identified.
- Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people's opinions.
- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.
- If evaluation findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.
- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. In addition to the draft report, USAID requests a management memo, which will be shared only with the USAID Washington Evaluation Team, concerning management issues or concerns that the team encounters during interviews and country visits. Topics to be included here are personnel issues, management issues, and any other concerns that the team would like to highlight for the USAID/Washington team. This will not be published or shared widely.

The report should use the following format:

- Abstract: briefly describing what was evaluated, evaluation questions, methods, and key findings or conclusions (not more than 250 words)
- Executive Summary: summarizes key points, including the purpose, background, evaluation questions, methods, limitations, findings, conclusions, and most salient recommendations (2-5 pages)
- Table of Contents (1 page)
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions: state purpose of, audience for, and anticipated use(s) of the evaluation/assessment (1-2 pages)
- Project [or Program] Background: describe the project/program and the background, including country and sector context, and how the project/program addresses a problem or opportunity (1-3 pages)
- Evaluation/Analytic Methods and Limitations: data collection, sampling, data analysis and limitations (1-3 pages)
- Findings (organized by Evaluation/Analytic Questions): substantiate findings with evidence/data
- Conclusions
- Recommendations
- Annexes
Country-specific annexes will be included in the evaluation report, to provide country-specific recommendations. In addition, the annexes will address specific evaluation questions for Thailand, Laos, and Angola.
- Annex 1: Thailand/Laos
- Annex 2: Angola
- Annex 3: Malawi
- Annex 4: Kenya
- Annex 5: Haiti/other countries
- Annex 6: Evaluation/Analytic Statement of Work
- Annex 7: Evaluation/Analytic Methods and Limitations ((if not described in full in the main body of the evaluation report)
- Annex 8: Data Collection Instruments
- Annex 9: Sources of Information
 - List of Persons Interviews
 - Bibliography of Documents Reviewed
 - Databases
 - [etc.]
- Annex 10: Statement of Differences (if applicable)
- Annex 11: Disclosure of Any Conflicts of Interest
- Annex 12: Summary information about evaluation team members, including qualifications, experience, and role on the team.

The evaluation methodology and report will be compliant with the [USAID Evaluation Policy](#) and [Checklist for Assessing USAID Evaluation Reports](#)

The Evaluation Report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XXI. USAID CONTACTS

	Primary Contact	Alternate Contact 1	Alternate Contact 2	Alternate Contact 3	Alternate Contact 4
Name:	Judy Chen	Cameron Wolf	Maria Au	Tisha Wheeler	Sarah Yeiser
Title:	Key Populations Branch Chief	Senior Key Populations Technical Advisor	Strategic Information Advisor	Senior Key Populations Technical Advisor	Program Assistant
USAID Office:	USAID/ Washington, Office of HIV/AIDS	USAID/ Washington, Office of HIV/AIDS	USAID/ Washington, Office of HIV/AIDS	USAID/ Washington, Office of HIV/AIDS	USAID/ Washington, Office of HIV/AIDS
Email:	juchen@usaid.gov	cwolf@usaid.gov	mau@usaid.gov	twheeler@usaid.gov	syeiser@usaid.gov
Telephone:	571-232-5690	571-451-3058	571-309-8806	571-236-5592	571-551-7405
Cell Phone					

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

	Technical Support Contact 1	Technical Support Contact 2
Name:	Lily Asrat	Chantal Auger
Title:	Senior Evaluation Advisor	
USAID Office:	USAID, Office of HIV/AIDS	USAID, Office of HIV/AIDS
Email:	aasrat@usaid.gov	cauger@usaid.gov

Telephone:	571 551-7192	
Cell Phone:	571-451-6079	

Michelle Kim, RDMA/Thailand

Joanna Cardao, USAID/Angola

XXII. OTHER REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

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XXIII. ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW (To be completed after Assignment Implementation by GH Pro)

- Evaluation team developed six country briefing notes
- Evaluation team held six country-specific de-brief meetings via conference call

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ANNEX II. EVALUATION METHODS AND LIMITATIONS

EVALUATION METHODS

Hypothesis

The core evaluation questions are the basis for a bifurcated hypothesis: a) LINKAGES *is or is not* an effective way to reduce HIV transmission among key populations (KPs) and improve their enrollment and retention in care; and b) course corrections in the program can/should be made that will improve outcomes along the continuum of services for these populations.

Core evaluation questions

1. How effective is the project in achieving its goals, objectives, and performance targets?
2. What are the project's strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?
3. What are the constraints to successful implementation of this program?
4. How well does the project align with PEPFAR and [USAID's Office of HIV/AIDS] OHA and global priorities and approaches?
5. Is there a need for a global follow-on key population (KP) mechanism?

Collectively, the evaluation questions are a modified SWOT analysis, which reflects the strengths-weaknesses-gaps-constraints paradigm underpinning the questions. The questions/analysis are a straightforward way to identify and categorize critical findings, use them to identify concrete recommendations for change/course-correction, and correlate them with LINKAGES' alignment with "PEPFAR and OHA and global priorities and approaches" (i.e., the fourth evaluation question).

Since this was a mid-term performance evaluation, it was not intended to be a rigorous quasi-experimental design, outcome or impact evaluation nor an attempt to directly attribute changes in health outcomes or impact to the project.

Evaluation types

The LINKAGES evaluation drew on three well-known types of evaluation:

- **Implementation/Operational Evaluation:** Focuses on what is happening in the project to determine what is working and what is not; determining whether the project is operating according to design.
- **Process Evaluation:** Examines how the project produces an outcome; searches for explanations of successes and failures in the way the project works.¹⁰
- **Outcome Evaluation:** Focuses on the kinds of outcomes the project produces in beneficiaries, including changes in behavior, attitude and skills; draws on indicator data generated by the project.

Mixed-methods approach

The evaluation used a mixed-methods approach, including document/data reviews, key informant interviews, direct observation, and secondary data analysis. Focus group discussions were used during

¹⁰ A process evaluation is a type of implementation evaluation.

the course of the evaluation. Each method focused on generating insights relevant to the five evaluation questions.

The country visits were rapid appraisals, relying on key informant interviews, direct observation, and focus group discussions. At the project level, rapid appraisals are an effective way to provide a qualitative understanding of socio-economic changes, interactive social situations and/or people's values, motivations, and reactions. They add context and interpretation to the quantitative data generated by the project and/or collected by the evaluation team.

The effective use of the mixed-methods approach, including in the rapid appraisals, relies heavily on the knowledge, experience, insights, and common sense of the evaluators. The specific questions asked during interviews and the issues/topics tracked during document reviews and secondary data analysis are derived directly from the core evaluation questions.

Logic models / theories of change / patient pathways / service continua

In addition to the evaluation questions themselves, the mixed-methods approach was guided by the relevant logic models, theories of change, patient pathways, and/or service continua developed and used by LINKAGES and its partners. Understanding what they are trying to do, how they are doing it, and how well they are doing it helped the evaluation team identify recommendations related to the course corrections that were an essential output of the evaluation.

LIMITATIONS

The review had a number of limitations. The principle limitations included the following:

- The evaluation team conducted site visits in six LINKAGES countries. These countries may not be representative of the situation in other project countries.
- The evaluation team found striking similarities and distinct differences in the countries that were visited.
- Responses from local implementing partners and other informants may have been influenced by the presence of LINKAGES staff during meetings and interviews or by pre-visit briefings by LINKAGES. Despite efforts by the evaluation team to create opportunities for implementing partners and other informants to speak freely, it is difficult to exclude the influence of LINKAGES as the managing and funding partner.
- Project data shows that progress and achievements vary, depending on the country context and the length of time and intensity of project interventions, making it difficult to identify overall trends. In addition, project data in many countries shows dramatic changes in performance from quarter to quarter, which also makes it difficult to track trends.
- There are multiple issues with project reporting and data. Specifically, global progress reports do not provide a clear overview or cumulative information about what has been achieved across LINKAGES countries. These reports, and country progress reports, summarize activities in the preceding reporting period but this is not done in a consistent way. This makes it difficult to track changes in activities and data from quarter to quarter as well as to understand overall achievements, particularly against quarterly/annual targets. In addition, definition of relevant key populations PEPFAR indicators changed during the project and project targets are changed each year. Thus, reported data have inconsistencies across different documents, and data are not always fully disaggregated by key population (e.g., in some cases men who have sex with men and transgender people are reported as a combined figure; in others, they are disaggregated).

ANNEX III. PERSONS INTERVIEWED

USAID – Washington, DC

Judy Chen, LINKAGES Agreement Officer's Representative

Cameron Wolf, Key Populations Senior Technical Advisor

Tisha Wheeler, Key Populations Senior Technical Advisor

Billy Pick, Regional Advisor, Key Populations Specialist

Maria Au, Strategic Information Advisor on Key Populations

Michele Russell, Deputy Director, Office of HIV/AIDS

FHI 360 – Washington, DC

Hally Mahler, LINKAGES Project Director

Parsa Sanjana, LINKAGES Deputy Director

Chris Akolo, LINKAGES Technical Lead

Megan DiCarlo, LINKAGES Senior Technical Advisor

Tiffany Lillie, LINKAGES Senior Technical Advisor

Navindra Persad, LINKAGES Senior Technical Advisor

IntraHealth International

Kate Stratten, Director for Southern Africa Programs

Pact

Brian White, Senior Technical Advisor

University of North Carolina

Sharon Weir, Research Assistant Professor

William Miller, Technical Advisor

LINKAGES Advisory Board

JoAnne Keatley, International Reference Group on Transgender Women and HIV/AIDS

Gina Dallabetta, Bill and Melinda Gates Foundation

Angola

USAID: Derrick Brown, Mission Director; Armando Cotrina, Senior HIV/AIDS Advisor; Joana Cardão, Project Management Specialist HIV/AIDS

LINKAGES: Ana Dias, Program Manager; Giuseppe Cristino, Senior Technical Advisor; Rafaela Egg, Senior Technical Advisor; Paula Sebastião, Technical Officer

MWENHO: Rosa Pedro, Director; Cecilia Olga Silva, psychologist; Nilton Andre, lawyer; Theresa & Andrea, counselors

INLS: Jose Carlos Van Dunen, Deputy Director; Isabel Fortes, Information Officer

FOJASSIDA: Nelson Pedro, Director; Euclides João, Administrator

ASCAM: Three supervisors, 11 PEs, nine beneficiaries, three counselors

Tchikos: Pedro Sapalalo, Director

Cuidade Infancia: Arnando Fernando, Director

ANASO: Antonio Coelho, Director

ABC: Ana Borges

UNAIDS: Kouassi Kouakou, Country Director; Ian Wanyeki, Strategic Information Advisor

UNDP: Mamisoa Rangers, Project Coordinator

Other: Jandira Gamboa, AFNET; Rebecca Turner, Director Procurement and Supply Management (PSM); Carlos Laudari, ICAP

Haiti

USAID: James Maloney

LINKAGES: Steeve Laguerre, Project Director; Johanne Hilaire, Project Manager; Jacob Michel, Strategic Information Manager; Raoul Vincent, Finance Manager; Rachid Dorsainvil, HIV Technical Advisor; Johanne Etienne, KP Technical Advisor; Max Bond St Val, KP Technical Advisor

PNLS: Blondine Jean Baptiste, M&E Officer; Bernadette Gaspard Christian, Communication Manager; Nirval Duval, Epidemiologist and M&E Manager; Emmanuel Pierre, Statistician; Kesner Francois, Care and Treatment Manager; Pavel Desrosiers, Director, MSPP/Unité de Coordination des Maladies Infectieuses et Transmissibles IST/HIV; Georgie Boulay

OHMASS/GF: Marie Suze Jacquet, HIV/TB Senior Manager

PSM Chemonics: Florence Guillaume, Program Director; Olivia du Moulin, Procurement Manager; Dumel Junior Monfort, Commodity Distribution Focal Point

SSPE Clinic, St Marc: Noeline Dasny Lindor, Nurse; Martine Mesadieu, Nurse

SEROvie Port-au-Prince: Marie Kettely Pierre Peigne, Health Program Manager; Yveline Malval, M&E Officer; Gregory Maurice, Project Manager; PE, PN and Peer Supervisor

SEROvie Gonaives: Clifford Cherisier, Program Manager; Renaldy Dessalines, Coordinator and Clinical Officer; Christine Cupidon, Nurse; Djenane Darius, Data Officer; Nirva Alfred, Laboratory Technician; Guy Rogenèle François, PN; Djoumy Darius, PE

FOSREF Gonaives: Moussef, Director; Etienne, Supervisor; Emmanuel Saint Mius, Social Worker; Merzelane Merzilus, Nurse i/c; Johnny Saint Bonheur, KP Technical Advisor; Sherna Sylvain, Project Officer; Brebord Rosinvil, DRO; 2 PEs, 1 PN

GHEKIO: Stanislas Gabaud, M&E Manager; Rude Secours, Technical Coordinator

Zanmi La Santé: Gerson Sergio Jeudi, Technical Lead; Robens Jean Baptiste, Data Officer; Johanne Dorvil, Coordinator; Paul Emile Ernst, Field Coordinator; Evens Cayemittes, Psychologist

CPFO: Myrlène Joanis, Project Technical Coordinator; Rita Vincent Jean Charles, M&E Coordinator; Djenane Ledan, Director; Cassandre Denis, Psychologist; 2 PEs, 2 PNs

Kenya

USAID: Vincent Ojiambo, Project Management, Youth and BCC Specialist; Sonia Gloss, Health Communication and Project Design Specialist; Joy Melly, Health Population and Nutrition Office; Katherine Farnsworth, Acting HIV/AIDS Team Leader

LINKAGES: Bernard Ogwang', Project Director; Njambi Njuguna, Senior Technical Advisor Clinical Services; Alice Olawo, Senior Program Officer; Chris Agunga, Senior M&E Officer; Bill Okaka, SBCC Adviser; John Wachira, Senior Finance Officer; Samuel Anzotse, Senior Contracts and Grants Officer; Sewe Malamba, Senior Program Officer, Coast Region

Technical Support Unit, NASCOP: Serah Malaba, Head; Parinita Bhattacharjee, Senior Technical Adviser; Timothy Kilonzo, Advocacy Officer; Paul Ngei Monyi, Information and Data Manager

KASH DIC Kisumu: Thomas Abol, Executive Director; Martha Opilli, Program Manager; Wycliffe Odera, Senior Program Officer; James Gwendu, Communication Officer, Grevins Odera, M&E Officer; Annet Clara, Clinician; Metrine Mibey, Volunteer Locum Clinician; Anna Sammy, Clinician; Sylvester Koyo, HTC Provider and Counselor; Corazon Okeyo, Legal Officer; Pamela Nyambega, Receptionist; Lilian Gitau, Project Officer; Perez Achieng, Paul Omondi, Dolphine Atieno, Outreach Workers; Angelina Kareche, Fred Abayo, Field Officers; Nancy Owala, Social Work Student; Kennedy Ogolla, CAB Chair

MAAYGO DIC Kisumu: Henry Victor Digolo, Director; Kenedy Otieno Olango, Program Manager; Simon Otieno, Finance Manager; Vincent Okoth Odira, M&E Officer; Godfrey Omuok, Project Officer; Ely Ondiek, M&E Assistant; Laura Alivesta, Clinical Officer; Benson Ouso, HTS Provider; Stephen Omondi, Outreach Worker; Samwel Okene, Office Assistant; 15 PEs and 10 DIC staff

PANGANI Nairobi HOYMAS DIC: John Mathenge, Executive Director; Erustus Ndunda, Program Manager; Chris Asingo, Finance Officer; Pascal Irungu, M&E Officer; James Ngungi, Felix Onyango, Trevor Mwaniki, Francis Kyengo, Outreach Workers; Christine Mutira, Data Clerk

KARIOBANGI Nairobi BHESP DIC: Mwangi Simon, Program Manager; Caroline Muloyo, Clinician; Musa Harun, M&E Officer; Monica Muita, Nurse; Purity Ikusi, Finance Officer; Priscilla Njoki, Field Officer; Petronila Auma, Data Clerk; Tamiza Chege, Mary Mugure, Betty Sande, Outreach Workers; Mary Mwangi, Advocacy Officer; Josephine Mutende, Legal Officer; Robert Rianga, Sub-County AIDS and STI Coordinator

CASCO Mombasa: Zeituni Ahmed, County AIDS and STI Coordinator; Margaret Njiraine, NASOP TSU Field Coordinator, Coast Region

CASCO Nakuru: Rachel Kyuna, Deputy Head of HIV Program; Jeremiah Kutwa, KP Program Coordinator

AFYA Pwani: Isaac Chome, Director Clinical Services

ICRH Kisauni DIC: Griffins Mang'uro, Director; Jefferson Mwaisaka, Program Manager; Faith Gitau, Nurse; Naomi Mtwana, Clinical Officer DIC i/c; Gladys Waruguru, Program Officer; Peter Mwakazi, Data Clerk; 3 PEs, 2 Peer Supervisors, 2 Community Mobilizers

NYDESO Jala DIC: John Odada, Director NYDESO; Philip Manuni, Administrative Assistant; Sheila Ilahalwa, Data Clerk

FAIR Nakuru DIC: Zipporah Odanga, Project Nurse; Bernard Rono, Nurse/HTS Provider; Richard Aginga, Finance Officer; Silas Nyaga, Veronica Amunga, HTS Counselors; Emmy Odaba, DIC Assistant; Janet Arusei, M&E Officer; Samuel Waithaka, Project Coordinator; Grace Karanja, Outreach Worker; Dennis Onyango, Data Clerk

KNOTE Naivasha DIC: Catherine Gathoni, Program Coordinator; Ochieng Ogutu, Project Manager; Aggrey Ongaro, Field Officer; Ruth Kiarie, Nurse; Lucy Njeri, Data Clerk

Pact: Jacqueline Ndirangu, Capacity Development Adviser and the Capacity Building and Institutional Development Team

In addition, PEs and beneficiaries at hotspots in Nyalenda; Police Officers at Kondole Police Station including Commander Simiyu, Station Commander, Inspector Zakayo Ekirapa; focus groups with FSW and MSM

Laos

USAID: Kongchay Vongsaiya, Health Program Adviser; Michael Kleine, Deputy Chief of Mission

LINKAGES: Philippe Girault, Technical advisor Strategic Information; Phayvieng Philakone, Program Coordinator; Oudone Souphavanh, Program Officer; Chanthone Ounaphom, Program Officer

Ministry of Health: Bounpheng Philavong, Director General, Department of Health and Hygiene Promotion

Center for HIV/AIDS and STIs (CHAS): Phouthone Southalack, Director; Khanthanouvieng Sayabounthavong, Deputy Director

LaoPHA: Vieng Akhone Souriyo, Chair; Sookai Phompiban, Project Manager; Alounlack Samountry, Finance Officer; Songphet, M&E Officer; Bounthand Sayyadeth, Accountant; Thavadxai Xaiyakoumman, Phonesavanh Nongphacanh, Community-Based Supporters

Mahosod Hospital (Government): Dr. Chiraha, Doctor; Bouakeo, Saykeo Vongsayyarath, Thidasavanh Amnatka, Nurse/Counselors

Youth Center (Government): Ya Phoummalinno, Doctor

Malawi

USAID: Beth Deutsch, Senior HIV Prevention Adviser and LINKAGES Activity Manager; Elizabeth Brennan, HIV Deputy Team Lead; Linda, DREAMS Project Manager

LINKAGES: McPherson Gondwe, Senior Technical Officer; Gift Kamanga, Senior Technical Adviser; Stanley Kalyati, Senior M&E Officer; Laston Mteka Banda, BCC Adviser; Maria Mkandawire, Senior Technical Officer; Elizabeth Mpunga, Senior Technical Officer; Melchiade Rubentwari, Country Representative; Louis Banda, Senior M&E Advisor

Department of HIV/AIDS, MOH: Thoko Kalua, Deputy Director; Stanley Ngoma, KP Focal Person; Andreas Jahn, M&E Technical Advisor; Michael Odey Odo, Treatment and Care, Technical Advisor; Tobias Masina, HTS Officer

NAC: Chimwemwe Mablekisi, Director Prevention Services; Shawn Aldridge, Senior Technical Advisor; Joel Suzi, Head of Behaviour Change Initiatives

Blantyre, Blantyre District:

Pakachere: Simon Sikwese, Executive Director; Freda Kantunibiza, DIC Manager; Mellia Kantimalelo, District Coordinator; Patrick Ngosi, M&E Officer; Barbara Kapenoka, Thandiwe Kaunda, Sophie Mchakaona, Towera Msiska, Jean Mpazo, Smya Kondowe, Outreach Workers; Eddah Nyirenda, Outreach Worker and PN

CEDEP: Gift Trapence, Executive Director; Weston Masuku, M&E Officer; Project Coordinator; DIC Manager; Nurse; Clinician

YONECO: MacBain Mkandawire, Executive Director; Daniel Chikatentha, M&E Manager; Chikondi Mlozi, District Coordinator; Bernadette Mweso, M&E Assistant; Loveness Bowa, DIC Manager; Henry Dzuwa, Susan Mwale, Ivy Bankulo, Hopson Sain, Outreach Workers

Counterpart International: Arthur Chingoka, Senior Capacity Development Specialist; Janet Mswayo, Senior Technical Capacity Building Specialist

In addition, PEs, PNs and Outreach Workers at hotspots in Lilongwe; DIC Managers in Chirimba and Monkey Bay; focus groups with MSM and FSW PEs and PNs in Chirimba, Lilongwe, Blantyre, Monkey Bay, Machinga and Naperi; Victim Support Officers, Monkey Bay Police; Dr. Mtchaya, District Health Officer, Blantyre District

Thailand

USAID: Ravipa Vannakit, Strategic Information Specialist and Activity Manager Thailand and Laos; Nigoon Jitthai, M&E Adviser; Jittinee Khienvichit, M&E Specialist; Marisa Sanguankhamdee, Program Management Specialist; Michelle Kim, Health Development Officer

LINKAGES: Stephen Mills, Regional Director; Sutinee Charoenying, Country Program Manager; Matthew Avery, Associate Director Health Population and Nutrition; Amornrat Arunmanakul, Senior Program Officer

Thai Red Cross: Nittaya Phanuphak, Chief of Prevention Department; Panus Na Nakorn, Program and Communication Strategist; Rena Janamnuysook, Transgender Program Coordinator; Peevara Srimanus, Program Assistant

Service Workers IN Group (SWING): Surang Janyam, Executive Director; Chamrong Pheangnongyang, Deputy Director; Denchai Srikrongthong, Human Resource Manager; Saman Sumalu, Clinic and M&E Manager; Surasak Naimtanom, Deputy Manager

Pulse Clinic: Wasana Sathianthammavit, Nurse/Counselor; Bhirachet Yaemim, Managing Director/Doctor; Natthakhet Yaemim, Medical Director

Asia Pacific Coalition on Male Sexual Health (APCOM): Ryan Figueiredo, Deputy Director; Safir Soeparna, Senior Campaigns and Communication Officer; Inad Quinones Rendon

Rainbow Sky Association of Thailand (RSAT) - Bangkok: Danai Linjongrat, Director; Detchapon Kalyanamitra, Project Coordinator; Kanyawee Macharoen, Deputy Director; Nippon Saejung, Strategic Information Manager; Rasinthra Sawasdinart, Manager; Manit Kittipirun, Field Officer; Somporn Sarwaew, Head of Lab; Nopparat Mahachokchai, Manager; Teppanan Sangiamjit, Manager

Sisters: Thitiyanan Nakpor, Director; Phonpiphat Potasin, Manager; Nanthika Praweprai, Medical Technologist; Kitjapong Krajan, Monitoring, Evaluation and Communication Officer; Chokchai Norat, Ramitcha Sukdipreechakul, Outreach Workers; Thanapat Worawatkraioet, Counselor, Care and Support Officer; Natchanin Auppanun, Counselor

SWING Pattaya: Manop Uthaikon, Project Manager; Supachai Sookthongsa, Pornpichit Brutrat, Counselors; Hansa Thiamkrathok, Care and Support Officer; Apichart Udomsirasirichot, Medical Technologist

Songkhla PHO: Tassanee Pongpaiboon, Public Health Expert; Charoensuk Chanawanno, Public Health Expert; Prateep Saramunee, Public Health Expert

Hat Yai Hospital: Usa Sutthapan, Nurse

Department of Disease Control Region 12: Chirabhron Attasupanapun, Nurse

RSAT – Hat Yai: Phooritat Yokchawee, Head of HTC; Sarayut Petchaithong, Medical Technologist; Fonthip Suwan, Counselor, Care and Support Officer; Oranong Chanasith, Manager; Noppanai Ritthiwong, Head of Outreach Services; Soonthron Kanyot, Community Relations Officer; Natlada Wongwiratchitra, Head of Quality Services; Adisorn Panmas, Learning Center Officer; Nattaporn Pongsavej, Accounting and Finance Officer; Yupawadee Chawanarak, Charassri Lappaboon, Counselors; Bhubej Pongsuwan, Lab Technician; Sasikorn Noomuen, Data Entry Officer; Ampaporn Mingmah, Learning Center Officer

CAREMAT: Satayu, Program Coordinator; Sapapun Kantasaw, Head of HTC; Pongsak Janlar, Care and Support Officer; Chulathon Sandrapanya, Head of Care and Support; Rathchadet Reankhamfu, Manager

Mplus: Pongpeera, Deputy Director; Rattawit Apipunthipan, Manager; Rattapoom, M&E Officer

Sarapee Hospital: Amarin Norchaiwong, HIV Coordinator

Chiang Mai Provincial Health Office: Chutima Charuwat, Public Health Expert; Withun Wongthip, Public Health Expert

Thailand MOPH/US CDC Collaboration (TUC): Thananda Naiwatanakul, Senior Policy adviser, Chief of Policy, Innovation and Communication Section

Ministry of Public Health (MOPH), Nonthaburi Province: Taweessap Siraprapasiri

Global Fund CCM Secretariat: Petsri Sirinirund

ANNEX IV. SOURCES OF INFORMATION

PEPFAR

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ANNEX V. COUNTRY REPORTS

- Angola
- Haiti
- Kenya
- Laos
- Malawi
- Thailand

ANGOLA COUNTRY REPORT

I. Introduction

Given the concentrated nature of the HIV epidemic in Angola, engaging with the female sex worker (FSW), men who have sex with men (MSM), and transgender (TG) populations is an essential part of the country's response. Without focused efforts to improve prevention, case detection, treatment uptake, and treatment retention among these key populations (KPs), Angola will not control its epidemic. However, the HIV response in the country has historically focused on the general population with limited attention to the KPs who carry a disproportionate share of the disease burden. In addition to the high burden of HIV in these populations, they also face intense and long-standing stigma and discrimination, which complicates efforts to reach them with vital HIV services.

II. Findings by Evaluation Question

Evaluation Question I: How effectively is the project achieving its goals and objectives?

Building on previous USAID work with KPs in the country, LINKAGES/Angola has demonstrated the value of an integrated approach to HIV prevention, testing, and treatment. LINKAGES has shown it is possible to deliver HIV services to these populations despite the difficult and challenging environment. However, LINKAGES performance in Angola has been mixed. Overall, performance has been better among FSW than among the MSM and TG populations, particularly in prevention and testing uptake. But testing yield, case detection, and treatment uptake lag across all three populations.

Table I. Indicator Performance, including percent change between FY 2016 and FY 2017, testing yield and treatment uptake

Core Indicators	FSW			MSM/TG		
	FY16	FY17	% change	FY16	FY17	% change
KP_PREV: Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	5,083	12,146	+139%	1,871	3,244	+73%
HTS_TST: Number of KP who received HIV Testing and Counseling (HTS) services for HIV and received their test results	1,715	7,589	+343%	352	1,699	+383%
HTS_TST_POS: Number of KP tested HIV positive (testing yield)	82 (4.8%)	190 (2.5%)	+132%	19 (5.4%)	47 (2.8%)	+147%
TX_NEW: Number of KP newly initiated on antiretroviral therapy (uptake)	54 (66%)	119 (63%)	+120%	9 (47%)	36 (77%)	+300%

Table I shows the significant year-over-year improvements in performance across the key PEPFAR indicators with major increases in every category for both FSW and MSM/TG populations. The only metric with a less than triple-digit increase was KP_PREV for the MSM/TG population, which still had a 73% jump between FY 2016 and FY 2017.

Table 2. Indicator Performance against fiscal year targets

Core Indicators	FSW		MSM/TG	
	FY16	FY17	FY16	FY17
KP_PREV	51%	121%	29%	50%
HTS_TST	21%	93%	7%	32%
HTS_TST_POS	No data	46%	No data	17%
TX_NEW	11%	35%	3%	13%

Table 2 shows LINKAGES/Angola also improved its performance against the PEPFAR targets between FY 2016 and FY 2017, including achieving 121% of its KP_PREV target for FSW in FY 2017 compared with 51% in FY 2016. In addition, LINKAGES nearly reached the HTS_TST target for FSW, increasing to 93% in FY 2017 from 21% in FY 2016. While the project continues to underperform against other key targets, there are encouraging signs of progress. There are also questions about the accuracy of the targets, particularly for the MSM and TG populations, but LINKAGES has made limited use of available data to inform or influence the target-setting process. It is important to note that delays in the completion of the Priorities for Local AIDS Control Efforts (PLACE) study in Angola did reduce the amount of relevant data that was available to the LINKAGES and PEPFAR team for target-setting.

Although the number of identified positives did increase between FY 2016 and FY 2017 for both FSW and MSM/TG, testing yield decreased during the same timeframe. The reasons for this are not clear but factors may include changes in Office of the Global AIDS Coordinator (OGAC) testing strategy and low incidence of new HIV infections among target populations. The introduction of a risk assessment questionnaire in May 2016 and targeted testing of high-risk KPs did appear to improve testing yield; OGAC advised a change of approach in FY 2017 to test all KPs regardless of risk and yield subsequently declined.

The increasing number of FSW and MSM/TG starting antiretroviral therapy (ART) (i.e., TX_NEW) is a positive development. The large increase in treatment uptake among MSM/TG is particularly notable, jumping from 47% of those testing positive in FY 2016 to 77% in FY 2017. There is evidence attributing this increase to the work of peer navigators (PN), who actively link clients with health facilities providing ART services and provide ongoing retention support. While the project improved its performance against TX_NEW targets between FY 2016 and FY 2017, increasing from 11% to 35% for FSW and from 3% to 13% for MSM/TG, achievements are well below the target and overall numbers remain low.

Evaluation Question 2: What are the project's strengths, weaknesses, and/or gaps in planning, management, service delivery, and sustainability?

I. Management and Oversight

During FY 2017, the LINKAGES/Angola team expanded and now has the requisite range of knowledge, skills, and experience required to provide better support to civil society partners and better services to KPs. LINKAGES/Angola has also forged productive relationships with government, health facility, and civil society partners. If the project can leverage its additional capacity and its positive relationships, it will be well placed to improve and increase its contribution to the national HIV response, including ensuring KP programs are integrated into the national response.

Strengths

- LINKAGES is playing a central role in raising awareness and improving knowledge about HIV prevention, testing, and treatment for FSW, MSM, and TG populations among stakeholders in Angola, including government institutions, funding partners, and civil society organizations (CSOs). LINKAGES is also providing a platform for advocacy about the essential contributions of KP-focused activities to HIV epidemic control.
- *LINKAGES' relationship with the Government of Angola's* National Institute against HIV and AIDS (INLS) has been critically important to the ability of the project to develop and implement integrated programs for KPs. Even more importantly, it has raised the profile – as well as knowledge and awareness – of HIV programs for KPs more broadly within INLS and the Ministry of Health. Given the central role of INLS in informing the development of HIV programs and replicating best practices, the positive relationship with LINKAGES has important implications for the future of KP programming in Angola.
- Given the current focus of LINKAGES activities in the capital city, the project's relationship with the Luanda Provincial Department of Health (DOH) has been equally important in building support for improved HIV services for KPs and developing an integrated approach to working with these populations. There is a keen awareness in the Department and in the health facilities that it operates of the value LINKAGES has brought to the local HIV response, particularly its ability to work with stigmatized MSM and TG populations.
- LINKAGES/Angola has taken steps to address management and contractual issues with local implementing partners, to build management capacity, and to hand over responsibility for performance and grant management. Efforts are also being made to increase implementing partner participation in project decision-making and planning, although LINKAGES' efforts to expand and improve collaboration could be strengthened.

Challenges

- The number and capacity of CSOs working on the HIV response in Angola is extremely limited, reflecting the nascent state of the civil society sector in the country. Given the central role that CSOs play in the LINKAGES approach to working with KPs, weakness in the sector and individual organizations have complicated the implementation of project activities.
- There have also been challenges associated with contractual arrangements, management, and performance of implementing partners over the life of the project. This appears to have been due to a combination of factors, including the limited capacity of CSOs to understand and meet grant requirements, assimilate and use guidelines, and collect and use data. They have also struggled to understand the cascade model, the focus on PEPFAR targets, and results-based financing. These challenges, together with weak management skills, poor performance, and differences in mandate and approach, resulted in some contracts not being renewed.
- The metrics used to track LINKAGES' performance do not recognize the level of effort, the wide range of activities, or the sustained contact required to motivate actions or change behaviors among KPs. There are also the additional hurdles of stigma, discrimination, social exclusion, and violence that make work with these populations more difficult and demanding. The pressure to reach PEPFAR targets with limited resources and inadequate recognition of the range of interventions required can result in a narrow focus on targets rather than on

implementing the full range of activities necessary to effectively meet them. As a result, it is an ongoing management challenge to ensure implementing partners strike an appropriate balance in allocation of resources and level of effort.

- Currently, LINKAGES is only implementing activities in a limited number of locations in Luanda (see Section 2). Interventions will need to be implemented at a larger scale to demonstrate that LINKAGES' approach can make a meaningful and substantial contribution to epidemic control among KPs and to convince government and other funding partners to invest more resources in HIV programs and services for these populations.

2. Delivery of HIV-related Services

LINKAGES and its local implementing partners are making an important contribution to service delivery for KPs, including introducing approaches that could improve the delivery, quality, and efficacy of these services. LINKAGES has had a direct effect on improved HIV prevention, expanded HIV testing, and increased uptake of and retention on ART in the FSW, MSM, and TG communities reached by project activities.

Strengths

- There has been an incremental expansion in the number of hotspots reached by LINKAGES/Angola over the life of the project. Coordinated and recurrent outreach activities at the hotspots have contributed to improvements against the KP_PREV, HTS_TST, and HTS_TST_POS targets.
- An approach based on the enhanced peer outreach approach (EPOA) model was piloted in 10 sites in Luanda Province and appears to have been effective in improving case detection. Based on lessons learned from the pilot, a broader EPOA campaign is planned to increase case finding among FSW and MSM, especially older and/or high-risk FSW and MSM. Given experience with EPOA in other LINKAGES countries, launching, sustaining, and learning from this campaign should be a priority.
- Local implementing partners have introduced different approaches to increase physical and virtual reach and identification of new KP contacts and networks, in particular among higher-risk MSM and TG populations. These include snowball sampling, risk assessment, prevention activities at MSM gatherings, an MSM call center, the use of social media to reach MSM and TG communities, and the use of SMS messaging to engage/re-engage high-risk FSW who have not been tested. The election of KP focal points by peers at hotspots has also helped to extend reach, improve prevention, and strengthen referral for testing; these focal points keep track of KP community members, manage distribution points for condoms and lubricants, and work closely with project field teams. (The use of KP focal points is an idea drawn from LINKAGES' experience in Kenya and Malawi.)
- HIV care and treatment in Angola is supported through a strong national program, under which the government provides free ART using a "test and start" approach. LINKAGES helped establish and now helps to maintain relationships between its civil society implementing partners and PEPFAR-supported government hospitals providing HIV confirmatory testing and ART services. The task of maintaining the critical, day-to-day relationship with the health facilities falls mainly to the LINKAGES PNs. Over time, the number, role, and capacity of PNs has been expanded, creating valuable support networks for KPs, and the PN "case management"

approach is strengthening referral, service uptake, follow-up, and retention of clients. The involvement of PNs has specifically and dramatically increased same-day ART initiation of clients who test HIV positive.

- LINKAGES/Angola piloted the use of comprehensive sexually transmitted infection (STI) testing as a way to improve HIV case detection. In this program, STI testing and treatment were offered to eligible, potentially high-yield participants (e.g., those with a previous positive STI screening and a history of anal sex, in accordance with World Health Organization recommendations for MSM and TG individuals who are not sex workers). The approach generated a significantly higher testing yield than other LINKAGES activities for these populations, which is in line with international studies and experience.

Challenges

- Despite efforts to establish reasonable size estimates of the different key populations, multiple stakeholders in Angola expressed concerns about the accuracy of the estimates, including conflicting concerns among different stakeholders that the estimates were too high or too low. In addition, there appears to be an absence of useful and/or used local/hyperlocal population size estimates, which could help improve project performance by identifying where and how to efficiently and effectively implement activities.
- Despite being an integral component of the LINKAGES approach globally, micro-planning does not appear to be done in a particularly robust way in Angola. Given the relationship of micro-planning to many of LINKAGES' activities and objectives (e.g., population size estimates, hotspot mapping, peer outreach, community needs, and ownership), prioritizing the ongoing and iterative use of micro-planning could have a direct impact on partners' performance. The different micro-planning tools and techniques could also be combined with basic quality improvement practices (e.g., Plan-Do-Study-Act) to understand and address under-performance in testing yield or uptake of ART.
- There are questions about the value of deploying three-person outreach teams to engage with KPs in the field. The teams, which include a peer educator (PE), a counselor, and a PN, are resource-intensive and, based on reported project performance, generate mixed results (e.g., low testing yield). The individual roles and skill sets of the different cadres of outreach workers is not an issue; clearly, each cadre has an important role to play in engaging and supporting clients. But the outreach teams need to be deployed in ways that are more efficient and more effective. In light of the difficult settings where outreach workers can be deployed, it is important to acknowledge that multi-person teams are one way to provide a measure of security.
- Outreach activities at physical locations are not always an effective way to reach individuals in the MSM and TG communities. Serious stigma and discrimination as well as concerns about privacy mean that many of the individuals and their meeting places are "hidden" or "under the radar." Social media enables more direct and discreet contact within these communities and reduces the need to meet at physical venues. LINKAGES/Angola reports that the project has started to use online and phone outreach to these populations in response to this shift. The constantly evolving dynamic makes it difficult for LINKAGES to stay abreast of where to engage with these communities in both the online and offline worlds.

- The high mobility of KPs and the rapid expansion of Luanda are also challenges for reach and retention, particularly given the need for sustained interaction to influence risk and health-seeking behaviors. For example, internal migration within Luanda and the continuing growth of the city is driving the emergence of new neighborhoods and new hotspots that are challenging for LINKAGES to serve, even with the knowledge that their client population is living and working in these new places.
- Effective and innovative approaches, including EPOA, the call center for MSM, and the use of STI testing, have been implemented in only a few sites and their reach is or was very limited. At the same time, LINKAGES appears to have been slow to adapt existing approaches, such as the strict use of three-person field teams, despite concerns about their performance and cost-effectiveness. The pressure to reach PEPFAR targets may be a factor, with implementers preferring to stick to what they know rather than trying something new that may not improve their results. However, there are people within the LINKAGES/Angola network who recognize the need to alter existing approaches. For example, field workers suggested the effectiveness and efficiency of outreach could be enhanced if PEs operated separately on occasion, if new sites were covered, and if teams worked more days or different days of the week. A more robust and consistent use of micro-planning and quality improvement tools and techniques should also help to lead to new approaches being trialed as well as additional ideas being generated. In addition, LINKAGES/Angola would benefit from strengthening consultation with project staff, volunteers, and clients. In this, it could learn from other LINKAGES countries (e.g., Kenya), where listening exercises have been institutionalized and change is more readily accepted.
- LINKAGES faces multiple challenges with HIV testing among KPs, each of which contributes to low testing yield. For example, fear of stigma and discrimination is a disincentive to being tested in health facilities. Concerns about privacy and confidentiality have a direct effect on the uptake of street-based and hotspot-based testing. Ongoing denial of their HIV status leads to repeat testing among KPs previously diagnosed as HIV positive. In addition, less invasive approaches to HIV testing, including oral fluid testing and self-testing, are not yet available in Angola.
- HIV treatment is equally challenging due to the relatively small number of government health facilities providing ART, a lack of trust in government health services, the distance and cost of getting to ART clinics, the lack of trained clinical staff, and concerns about stigma and discrimination. LINKAGES PNs are able to help clients overcome many of these challenges, but the number and reach of PNs is limited.
- There is a lack of community-based HIV clinical services for KPs. Currently, LINKAGES/Angola only operates one drop-in center (DIC) that provides services for KPs, and its location makes it difficult for many people to reach. Even though LINKAGES provides a transport subsidy to clients to enable them to come to the DIC and this has improved utilization rates, the distance and travel required to reach the center are still a problem for some clients. Implementing partners highlighted the need to increase the number of DICs and expand the use of mobile clinics to improve coverage and uptake of HIV-related services.
- Viral load testing was only launched in Angola in July 2017. To date, the number of people who have been tested is relatively small. However, the National Institute of Public Health (INSP) has agreed to offer viral load testing to eligible HIV-positive KPs who are participating in LINKAGES programs. Ensuring KPs have access to this testing, and supporting scale-up of viral load testing, should help LINKAGES/Angola structure its activities to improve ART retention and viral

suppression. One of the added challenges with viral load testing is that many people in Angola, including health workers, outreach workers, and KPs themselves, have a limited understanding of the implications of viral suppression for their health and for HIV transmission.

3. Community and Civil Society Engagement

Strengths

- At the grassroots level, LINKAGES implementing partners appear to have generally positive relationships with the members of the FSW, MSM, and TG communities who are reached by project activities. However, concerns about stigma and discrimination, particularly in the MSM and TG communities, continue to adversely affect the uptake of HIV-related services, even when they are promoted and provided by welcoming, KP-friendly individuals and facilities.
- LINKAGES/Angola has provided valuable capacity building and organizational development support to local implementing partners. This has resulted in measurable improvement in partner capacity in many different areas, including management and finance, organization and delivery of outreach services, recruitment and training of PEs, counselors and PNs, social and behavior change communication, risk assessment, and condom/lubricant promotion. For many partners, this support has positively transformed how they operate.
- LINKAGES has raised awareness among CSOs both within and outside its network of implementing partners about the importance of improving governance, management, and operations if organizations want to make substantive and sustained contributions to their communities. Given the limited number and capacity of CSOs in Angola, this increased awareness could have a long-term impact on the evolution of the sector as a whole.
- LINKAGES has advocated for increased KP leadership and participation among its local implementing partners, and qualified individuals from different KP communities have gradually been promoted to more senior positions. In addition, there has been a steady increase in the number of PNs who are members of the different KP communities.

Challenges

- The small number of CSOs – and the even smaller number of KP-led organizations – makes it difficult to scale-up the HIV response for KPs in the country. Without greater attention to the viability of CSOs in Angola, it will be difficult or impossible to sustain and/or expand vital HIV-related activities with these populations. LINKAGES could accelerate efforts to broaden its network of partners to include informal organizations (e.g., movements) that have the potential to improve reach to MSM and TG communities in the short term and could evolve into full-fledged CSOs over the longer term.
- Government acceptance of the role of CSOs has historically been low in Angola. However, it is possible the new government may be open to broader engagement with civil society. Taking advantage of this opportunity could be a significant step forward for organizations working on HIV and with key populations.
- The CSOs working on the HIV response in Angola are highly dependent on financial support from the international donor community and their viability depends on continuing external funding.

- There appears to be no significant engagement by private health care providers in the HIV response among KPs in Angola, even though many Angolans seek health care outside of the country because of the limited availability of quality services. In many other countries, private sector providers play an important role in providing quality services for key populations and this could perhaps be explored further in Angola.

4. Structural Interventions

Strengths

- LINKAGES conducted training for health workers in government health facilities with the aims of reducing stigma and discrimination and creating a more conducive and friendly environment for KPs in public health facilities. Some local implementing partners are also organizing regular meetings with health facilities to identify ways to reduce stigma and discrimination. The Provincial DOH in Luanda readily acknowledges the benefits of the training and would like it to be expanded to other hospitals to increase the number of KP-friendly referral points for HIV-related services; the Department would also like to have follow-on training. Nurses who participated in the training acknowledge its role in changing how they work with KPs, and would like to see more of their colleagues receive the training.
- LINKAGES has only recently started work on violence prevention and response interventions and, so far, has focused on increasing awareness of gender-based violence (GBV) and rights among FSW. The rationale is that this will increase FSW trust in the project and increase uptake of HIV testing and treatment. In a short time, the project has sensitized a considerable number of FSW at hotspots, and is also raising awareness among FSW and MSM through group activities. In addition, advocacy and training for the police is planned, as is a system for easier/better reporting of violence. LINKAGES/Angola has also been instrumental in ensuring that GBV interventions, including HIV testing and post-exposure prophylaxis for GBV survivors, were included in the Global Fund application.

Challenges

- LINKAGES-supported structural interventions are at an early stage in Angola. The number of KP-friendly facilities where health workers have been trained is small, but the need to educate, orient, and build the capacity of health workers to provide quality, stigma-free HIV services to KPs is large. While LINKAGES/Angola does not have the resources to expand this training, it could provide technical support to the Luanda Provincial DOH and other partners to do so.
- Building positive relationships between KPs and health facilities is a slow process, and it will take time and additional sensitization before it has a significant impact on referral and uptake of services. Health workers are reluctant or resistant to provide specific services for KPs, and many KPs have concerns about stigma, discrimination, privacy, and confidentiality.
- Other structural interventions, including psychosocial support, nutrition, literacy, economic empowerment, and legal services for KPs, are also critical in retaining these populations in HIV programs, but these interventions are currently outside the scope of the project. In their role as *de facto* case managers, PNs do provide some basic elements of these interventions, but time and resource constraints limit what they are able to do.

5. Strategic Information

Strengths

- Although data on KPs is limited in Angola, LINKAGES has made good use of existing data to inform its planning process. For example, the project used knowledge about more than 100 hotspots that were identified during the USAID-funded PROACTIVO project. LINKAGES is also working to tap the local knowledge of its implementing partners to collect updated information on relevant issues, including hotspot locations and risk behaviors. In addition, data generated by the PLACE methodology is helping to identify hotspot clusters and locations and to develop population size estimates for the project's work in Luanda Province. Unfortunately, delays in PLACE implementation and analysis meant the findings were not available until late 2017.
- Efforts have been made to harmonize project and national data collection and reporting systems. For example, the Ministry of Health has introduced new registers where health workers can record clients as KPs when this is confirmed by the escorting PN and, in principle, follow-up data on KPs on treatment is shared with PNs.
- There is a strong culture of data use in the LINKAGES management team. Members of the team are well versed on the relevant data points, particularly those used for monitoring performance. More importantly, there appears to be an emerging culture of data use among the LINKAGES/Angola implementing partners. For example, outreach staff and their managers have a growing awareness of and appreciation for program data, although they are struggling with the pragmatic aspects of using it.

Challenges

- There is a general lack of contextual data or analysis at the field/outreach level that would help LINKAGES/Angola understand why things are or are not happening and what actions can be taken to improve performance. For example, knowing why members of the MSM community are reluctant to test or are unwilling to initiate ART is vital, if LINKAGES is going to reach its targets. The lack of good information on “why” makes it more difficult to understand “how” to adjust to improve performance/outcomes. Similarly, while analysis of leaks in the cascade is being done to a certain extent, it is not as connected to the day-to-day, practical work done in the field where insights from the data would be most useful.
- LINKAGES/Angola could also take a more proactive approach to the use of monitoring data for operational planning. Local implementing partners conduct weekly data review meetings, but these appear to focus more on verification and PE and PN performance against targets rather than on use of data to reflect on and improve approaches.
- Collecting data and reporting on LINKAGES custom indicators is time-consuming and does not appear to add significant value to project planning or implementation.
- Given the mobility of KPs and the dynamic nature of hotspots and risk behaviors, more frequent updating of local and hyperlocal population size estimates, mapping, hotspot validation, and risk assessment is required to better inform target-setting and operational planning.
- It is unclear why LINKAGES has not made more strategic use of the data that is available. For example, integrated mapping of different data points would quickly highlight the logistical and operational challenges facing the project, including the discordant placement of the sole DIC,

high-priority hotspots, transportation corridors, and KP-friendly health facilities. On a parallel note, LINKAGES could also provide more support to local implementing partners for micro-planning and integrated mapping that includes known hotspots, KP-friendly service points or potential service points and condom/lubricant distribution sites.

- Although collaboration between PNs and public health facilities has improved, data collection forms and unique identifiers are not consistent, or consistently used, across facilities, and data on client case management is not always shared with civil society partners, making it difficult for them to track client retention in treatment.

Evaluation Question 3: What are the constraints to successful implementation of the program?

- Stigma and discrimination towards KPs is widespread in Angola, contributing to an unwillingness to be identified as an FSW or a member of the MSM or TG communities, particularly when accessing health services. This makes it very difficult to reach at-risk members of KP communities and is a significant barrier to the uptake of HIV services.
- Stigma and discrimination towards people living with HIV further complicates follow-up and tracking of clients. For example, after an HIV-positive diagnosis, many MSM are reported to seek ART from health facilities as far away as possible, to minimize the risk of being identified. Even condoms are stigmatized because of their association with HIV.
- Sexual harassment and violence towards KPs, including by the police, is perceived as “normal” and considerable efforts will be required to change this mindset. The legal system provides little protection for KPs. The risk of violence also prevents outreach workers from working in some sites. For example, staff at CSO partner organizations report that they do not work the “marathona” or “free markets” because they believe there is a high risk of violence due to substance abuse during these events.
- The limited number and capacity of CSOs, in particular KP-led organizations, is a major constraint to implementation at scale, as is the general lack of knowledge and skills relevant to working with KPs among these organizations.
- Health policies and health system weaknesses are also a constraint. Currently, national policy does not allow community distribution of antiretrovirals (ARVs), although changes to this policy are reported to be under discussion. In addition, Provincial DOH in Luanda and hospital staff recognize that there is a need for clinical training focused on HIV-related services for KPs. There are also shortages of drugs, in particular STI drugs, and only one clinic provides STI services specifically for MSM.

Evaluation Question 4: How well does the project align with PEPFAR and OHA global priorities and approaches?

The work of LINKAGES/Angola is strongly aligned with PEPFAR and USAID Office of HIV/AIDS (OHA) global priorities and approaches, especially partnerships and work with key populations. The core PEPFAR and OHA commitment to partnerships is a fundamental component of the LINKAGES work in Angola. The project maintains productive partnerships with government at national and provincial levels and with CSOs.

The project's use of an expanded cascade to plan, implement, and measure its activities is also a clear reflection of its alignment with PEPFAR and OHA's commitment to epidemic control. LINKAGES acknowledges the importance of the 90-90-90/95-95-95 approach and objectives and their influence on its work.

In addition, the LINKAGES global and Angola-specific focus on work with KPs is closely aligned with the priorities of PEPFAR and OHA. PEPFAR is very clear about its support for work with these populations, stating on its website: "PEPFAR stands firmly and unequivocally with key populations. These groups include gay men and other men who have sex with men, people who inject drugs, sex workers, transgender persons, and prisoners." The website is equally clear about one of the primary reasons for working with these populations: "In almost every country in the world, members of these populations are at greater risk for HIV than the rest of the population. Globally, these key populations account for 45 percent of new HIV infections, according to UNAIDS, although they make up a much smaller proportion of the total population."

III. Recommendations

LINKAGES/Angola is doing vital work to ensure that KPs receive essential HIV services. The following recommendations are proposed as "course corrections" to help improve performance and impact.

- **Strengthen use of micro-planning and data to improve operational planning and implementation.** Micro-planning is a proven approach that, combined with quality improvement approaches, can play a significant role in improving the effectiveness of community-based activities. More specifically, LINKAGES should consider doing community mapping in key areas of Luanda (e.g., using the Site Walk approach used by LINKAGES/Malawi) and triangulating with the PLACE data to improve targeting of activities.
- **Intensify efforts to reach high-risk and hidden populations.** This should be supported by micro-planning and build on some of the more innovative approaches LINKAGES/Angola has used to facilitate reaching high-risk and hidden populations. LINKAGES should also expand its partnerships with formal and informal organizations that have the potential to engage with hard-to-reach sub-populations within KP communities and develop strategies to ensure the safety of outreach workers at hotspots and/or events where there is a risk of violence.
- **Scale up effective approaches to HIV case detection.** LINKAGES/Angola should increase its focus on HIV case detection across all KPs using "high-yield" approaches, including scale-up of EPOA, STI testing services, and other promising approaches, such as online outreach, particularly for MSM and TG populations. Related to this, LINKAGES/Angola should take steps to test different approaches to the composition and deployment of field teams and to provide more private spaces for HIV testing at hotspots to improve case detection.
- **Continue to move toward case management as a way to improve performance across the cascade.** LINKAGES PNs are increasingly acting as *de facto* case managers, who work closely with their clients to ensure they remain engaged with health services. An abstract submitted by LINKAGES/Angola and accepted by Independent Communications Authority of South Africa (ICASA) in 2017 makes a compelling case for the role of PNs. After only three months of using PNs, treatment uptake increased from 19% to 43%; after nine months of implementation, uptake reached 58%. After a full year of implementation, 67% of those who initiated treatment during the first nine months remained on treatment.

- **Work with government partners to strengthen client tracking.** The potential to develop a national Unique Identifier Code system that could be used by project implementing partners and by public health facilities should be explored. In the interim, efforts to improve data-sharing between implementing partners, especially the PNs, and health facilities should be strengthened to improve tracking of clients across the cascade.
- **Continue improving relationships with local implementing partners.** LINKAGES/ Angola should build on efforts to date to strengthen participation of implementing partners in project planning and decision-making in order to capitalize on their knowledge and experience, to institutionalize listening to field staff, and to build partners' management and organizational capacity.
- **Extend training for health workers.** Training on providing KP-friendly services should be rolled out to more health facilities, including strategically located facilities that could be effective referral points for LINKAGES clients. Expanding the number of referral points should have a positive effect on testing uptake, ART uptake, and ART retention. LINKAGES should also explore the potential for the government to directly support a wider rollout of stigma and discrimination training for health workers.
- **Provide evidence for long-term resource mobilization and sustainability.** LINKAGES should aim to generate evidence on effective approaches to delivering HIV services to KPs that could be used to make the case for increased domestic financing and support from other funding partners, including the Global Fund, both to take the approach to scale and to ensure the longer-term sustainability of KP programming within the national HIV response. This should include implementing violence prevention and response interventions at sufficient scale to demonstrate their effectiveness and cost-effectiveness.

HAITI COUNTRY REPORT

I. Introduction

In close partnership with the Ministry of Public Health and Population (MSPP), the National Program to Fight AIDS (PNLS), and local implementing partners, LINKAGES/Haiti is using a variety of service delivery approaches to meet project objectives and targets. Despite some delays in start-up, LINKAGES/Haiti has made impressive gains since FY 2017 Quarter 2 (about one year after project initiation) in reaching female sex workers (FSW), and, since FY 2017 Quarter 3, in reaching men who have sex with men (MSM). Areas needing further attention include enrollment and retention in care and treatment (especially for MSM), programmatic size estimation and mapping, and preparation of peer educators (PEs) to use micro-planning to guide their work. Given the pervasive violence and stigma towards key populations (KPs) in Haiti, better integration and strengthening of structural interventions within the project are also needed. Finally, given that capacity-building of local partners is crucial to the LINKAGES model, the reduction in organizational development support to local partners starting in FY 2018 seems premature.

II. Findings by Evaluation Question

Evaluation Question 1: How effectively is the project achieving its goals and objectives?

The data points in Tables 1 and 2 show steady improvement in project performance, including year-on-year increases across nearly all the key PEPFAR indicators and the associated targets. Although KP_PREV targets for FSW were reduced for FY 2017 (KP_PREV was not reliably counted in FY 2016 and steps were subsequently taken to reduce duplication), LINKAGES was more successful in increasing testing uptake for FSW, which doubled between FY 2016 and FY 2017. Both KP_PREV and HTS_TST indicators show improvements over time for MSM as well.

Table 1. Indicator Performance, including percent change between FY 2016 and FY 2017, testing yield and treatment uptake

Core Indicators	FSW			MSM/TG		
	FY16	FY17	% change	FY16	FY17	% change
KP_PREV: Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	45,358	32,445	-28%	11,395	13,900	+22%
HTS_TST: Number of KP who received HIV Testing and Counseling (HTS) services for HIV and received their test results	14,808	21,268	+44%	4676	8,889	+90%
HTS_TST_POS: Number of KP tested HIV positive (testing yield)	555 (3.8%)	818 (3.9%)	+47%	401 (8.6%)	456 (5.1%)	+14%
TX_NEW: Number of KP newly initiated on antiretroviral therapy (uptake)	185 (33.3%)	689 (84.2%)	+272%	137 (34.2%)	350 (76.8%)	+155%

Table 2. Indicator Performance against fiscal year targets

Core Indicators	FSW		MSM/TG	
	FY16	FY17	FY16	FY17
KP_PREV	128%	124%	83%	101%
HTS_TST	99%	117%	94%	94%
HTS_TST_POS	No data	52%	No data	55%
TX_NEW	38%	48%	27%	47%

During the first two years of the project, HIV testing yield has been lower than expected for both FSW and MSM. However, data from FY 2018 Quarter 1 (not shown) suggest positive trends in several sites, especially for FSW yield, which went from 3% in FY 2017 Quarter 1 to 4.4% in FY 2018 Quarter 1. In specific sites, the trends appear to be even more positive. For example, Zamni Lasante's SSPE Saint-Marc clinic went from a 2% yield for FSW in FY 2017 to 12% in FY 2018 Quarter 1, and from 3% to 13% in the same timeframe among MSM, although numbers are small for both groups. Concurrently, the yield of the *Centre de Promotion Femmes Ouvrières* (CPFO) among FSW in Port-au-Prince went from 2% to 7% for FSW over the same timeframe.

Although absolute numbers fell short of targets and vary across partners, treatment uptake for both populations improved considerably as well, reaching 84% for FSW and almost 77% for MSM in FY 2017. Data available from FY 2017 on viral suppression suggest rates of 63% among the 115 MSM tested for viral load (VL), and 57% of the 116 FSW tested, short of the 90% target. However, it should be noted that VL testing is centralized and capacity is limited; only the national public health laboratory is currently able to perform this type of testing and it provides this service for all health facilities in the country delivering ART.

Evaluation Question 2: What are the project's strengths, weaknesses, and/or gaps in planning, management, service delivery, and sustainability?

I. Management and Oversight

LINKAGES/Haiti maintains a core technical and administrative management team in Port-au-Prince based at the FHI 360 office, with other staff assigned to the departments (i.e., administrative regions) where the project is active. LINKAGES collaborates with five local organizations: GHESKIO; Zanmi Lasante; *Fondation pour la Santé Reproductrice et l'Éducation Familiale* (FOSREF); CPFO; and Fondation SEROVie.

Strengths

- LINKAGES/Haiti is contributing to improvements in national technical capacity. The project is closely aligned with the MSPP and PNLS and actively seeks to coordinate with the Global Fund Principal Recipient (PSI's local affiliate, OHMASS) and sub-recipients. It has contributed significantly to the development of a Key Population (KP) National Peer Education Training Manual as well as to national pre-exposure prophylaxis (PrEP) guidelines. In addition, the LINKAGES/Haiti team was a key partner in the joint 2016 National Cascade Assessment and participated in developing the Global Fund Concept Note. It also plans to convene two national meetings on reaching KPs in FY 2018.
- LINKAGES' local and international partners bring an important range of strengths needed to effectively reach KPs. Working in 14 sites in seven of Haiti's 10 departments, the five local

partners bring strong mobile service capacity, clinical infrastructure, and geographic coverage to the project, especially for reaching FSW. With the addition of two new partners in FY 2018, including one (Kouraj) that is KP-led and focused on MSM, the project's ability to reach KPs should continue to improve. LINKAGES/Haiti has made good use of global partners, including the University of North Carolina for the Priorities for Local AIDS Control Efforts (PLACE) study, Pact for capacity-building, the University of Manitoba for technical guidance, and IntraHealth for health worker training on reducing stigma and discrimination towards KPs, as well as collaborative work with EQUIP on PrEP.

- LINKAGES/Haiti's involvement in pilot projects is helping to ensure that the country is benefiting from service delivery innovations and new technologies. For example, LINKAGES will help support the introduction and evaluation of PrEP, as well as potential testing innovations, which will inform future national strategic plans.

Challenges

- Although the management team is now sufficiently staffed, personnel changes (e.g., the project manager position) and frequent turnover among partner staff and PEs has led to some delays in the project becoming fully operational.
- Top-down target-setting without commensurate budget adjustments has led to some discontent among partners. Targets are generally not based on field-based data and partners reported that targets had been increased by the US government without consultation, leading to frustration, especially since budgets remain static.
- LINKAGES/Haiti currently works in seven departments of the country, but collaboration with departmental health authorities and regional PNLS staff seems to vary across departments. Meetings at the department level to review data and project strategy did not occur in FY 2017 due to lack of funding.
- Working with KPs to improve HIV-related prevention, testing, treatment, and retention requires more intensive and sustained efforts than comparable work with other populations, in part due to stigma, discrimination, and social exclusion. Likewise, reaching the PEPFAR targets requires a wide range of activities and repeated contacts that are not captured or reflected in indicators or project reporting. The pressure to reach PEPFAR targets, and limited recognition of the range of interventions required, can result in a narrow focus on targets rather than on implementing the full range of activities necessary to achieve them.
- Opportunities for collaboration and coordination with other implementing partners and facilities seem to be missed in some settings. Although LINKAGES/Haiti partners, in some cases, are working in the same regions (e.g., SEROVie, GHESKIO, FOSREF), collaboration among them appears to be weak, leading to missed opportunities to leverage their respective strengths and assets. Some LINKAGES partners are also implementing similar programs through other funding (e.g. Kombat Vyolans), but coordination with LINKAGES project work is limited.

2. Delivery of HIV-related Services

Strengths

- LINKAGES/Haiti has developed a minimum comprehensive package of services for KPs that includes HIV prevention and risk assessment, testing, treatment, retention, and VL testing.

Other services, such as sexually transmitted infection (STI) testing and treatment, family planning, TB screening, gender-based violence (GBV) screening, and post-GBV care, including post-exposure prophylaxis (PEP), are also included. This package is delivered through a combination of institution- and community-based approaches, which include clinical outreach and mobile services; static health facilities to which clients are referred; and four drop-in centers (DICs). Static services have arranged for special entry points for KPs and, in hybrid sites (GHESKIO and Hôpital Saint Antoine of Jérémie, and Zanmi Lasante SSPE and CMCC), KPs can be fast-tracked for treatment initiation when accompanied by peer navigators (PNs) or other outreach workers.

- Hotspot mapping and size estimation using the PLACE methodology was conducted in all 10 geographical departments in Haiti during FY 2015. The PLACE study results provided a strong foundation for early project planning and targeting of sites. Service delivery points and hotspot targeting are now updated approximately every six months using GPS mapping and PE-led hotspot assessments.
- PEs are well trained and supervised to provide the full array of mobilization and education services, including distribution of condoms and lubricant, and referrals to testing. In FY 2017, PEs began using a standardized risk assessment tool and tailoring health education and behavior change messages and materials to better respond to client needs. A supervision structure is also in place. Interviews with PEs suggest strong ownership of and commitment to their work.
- The use of the Enhanced Peer Outreach Approach (EPOA) in specific sites resulted in significant improvements in yield of HIV-positive individuals. For example, at the Zanmi Lasante SSPE site in Saint-Marc, early project mobilization efforts were leading to a significant number of testing referrals, but HIV positivity was quite low. Through EPOA, which included improved risk assessment and community-based testing, yield among FSW rose significantly, from 2% in FY 2017 to 12% in FY 2018 Quarter I.
- A project-based Unique Identifier Code (UIC) system facilitates tracking of clients on the prevention side of the cascade. This system allows for monitoring up to the testing point in the cascade, although it does not extend into tracking clients enrolled in treatment, especially when they move from one provider to another among partners within the LINKAGES project. LINKAGES/Haiti is currently in discussions with PNLS and Global Fund partners regarding the harmonization and nationwide adoption of a UIC system and/or fingerprint identification that would encompass prevention, care, and treatment.
- During commodity shortages (e.g., condoms), larger, clinical partners have been able to access supplies from other sources, thus enabling PEs and PNs to continue distributing condoms and lubricants to clients.
- Through its partners, LINKAGES/Haiti has developed a strong network of hybrid clinical sites, mobile clinic services, and, to a lesser extent, DICs. These models include “One-Stop Shop,” night-time prevention, and testing outreach services in some sites, as well as fast-tracking for treatment enrollment at GHESKIO and ZL sites when clients are accompanied by PNs. Through GHESKIO, the project is also collaborating with a public hospital in a form of public-private partnership. The diverse service delivery models and strong clinical infrastructure have increased the project’s ability to meet client needs. To assess client satisfaction with services, the project is undertaking a survey at St. Antoine Hospital.

- Antiretroviral therapy (ART) service delivery is now provided in 13 sites. This includes ART provision for the first time in a KP-led site (SEROvie). The project is also working to establish multi-month prescribing to reduce treatment interruption.
- PNs are well-trained and successfully providing a comprehensive service package for newly diagnosed HIV-positive clients, including linking them to treatment. PNs are generally present during mobile outreach, as well as at clinical sites. They are also trained to escort newly identified HIV-positive clients to static treatment services. Additional PN responsibilities include providing psychosocial and ART adherence support, providing reminders for VL testing, distributing condoms and lubricants, and making referrals to clinics for other types of care.
- All sites have access to VL testing, with results available within two to four weeks.

Challenges

- Methodologies for KP size estimation, mapping, and micro-planning are not used consistently across sites, despite the formative work done with PLACE. While efforts are being made to routinely update mapping, programmatic size estimates are not updated or undertaken systematically across all sites, and the methodologies being applied are not strong. Although a comprehensive micro-planning toolkit was introduced in FY 2017, it is not being used consistently or fully, which impedes hotspot updating, commodity forecasting (e.g., condoms and lubricant), and effective use of data to continuously refine site-based strategies.
- LINKAGES/Haiti has only established four DICs among its 14 sites. While this may be a function of insufficient resources, the demand for additional safe spaces for KPs, where they can seek mutual support as well as clinical services, appears strong.
- Technical and financial support for PEs and PNs may not be sufficient for their expected scopes of work. The success of the LINKAGES model rests on the use of PEs, PNs, and field staff to reach, test, link to, and retain KP clients in treatment. PEs and PNs perceive their monthly allowance to be low, which may have a negative effect on morale and retention (although USAID notes that in comparison with other health staff in Haiti the allowance is relatively high). Other factors may be at play and this requires investigation. For example, PNs who were interviewed by the evaluation team reported that they did not feel sufficiently supported or valued for their work. They also requested that they be given access to psychosocial support for themselves, as well as additional training on addressing concerns of family members of HIV-positive clients. Feedback from several PEs and PNs suggested that stipends for transport may not be sufficient. They also noted that lack of nutritional supplements or other benefits for clients impedes their ability to link clients to testing and treatment.
- LINKAGES/Haiti has not established clear PE- or PN-to-client ratios, leading to wide variability across partners. In addition, some partners reported that they had not had sufficient refresher training or received new tools.
- Tracking of clients as they move through the care and treatment cascade remains difficult. This is particularly true when clients move from community-based mobile or outreach services to larger public health facilities, even when referral facilities are LINKAGES/Haiti partners, suggesting weak partner coordination. In addition, the UIC system is not being used consistently across all project partners, which hampers tracking of clients and determining why and at what

stage clients are dropping out of care. Finally, KPs are very mobile, often moving within the country as well as leaving for other countries.

- The project's activities for MSM are relatively modest, compared to efforts to reach FSW. Male sex workers and transgender (TG) populations are not being specifically targeted as the project does not have PEPFAR targets for these KPs. Although CPFO and FOSREF are working with non-brothel-based and informal FSW through informal PEs, activities are not strategic or structured, but LINKAGES/Haiti reports that this will be addressed by the planned use of EPOA for these FSW.
- Some outreach and navigation workers are not members of the KPs being served. This seemed to be mainly the case at the GHESKIO sites. The impact of this on service delivery is difficult to gauge, but there are indications that true "peers" may be more effective as educators and navigators.

3. Community and Civil Society Engagement

Strengths

- The LINKAGES project has provided important capacity-building technical assistance and systems for measuring organizational development. An important hallmark of the LINKAGES model is its focus on building capacity of local community-based organizations, especially those that are KP-led, to significantly contribute to epidemic response. As noted, LINKAGES/Haiti is currently working with five main local partners, one of which (SEROvie) is KP-led. With LINKAGES' support, these groups are successfully creating localized, KP-specific platforms for delivering essential services tailored to MSM and FSW needs. Several partners expressed great appreciation for the support they have received including use of the Integrated Technical Organizational Capacity Assessment (ITOCA) method of organizational assessment, developing institutional strengthening plans, and periodically measuring improvement over time using the Organizational Performance Index (OPI). The support was especially important to local partners such as SEROvie, which had been functioning primarily as advocacy organizations before LINKAGES and now are scaling-up service delivery.
- The fact that LINKAGES/Haiti sought advice from LINKAGES/Botswana on how to implement EPOA is a good example of cross-project, south-to-south learning that should be applied more often across the LINKAGES network of countries.

Challenges

- There are insufficient numbers of KPs in leadership and management positions among LINKAGES partners. LINKAGES/Haiti would benefit from identifying and supporting additional organizational or individual KP leadership through focused capacity-building exercises.
- Programmatically, LINKAGES/Haiti needs to focus more attention on finding vulnerable MSM populations, as well as differentiating services and care for TG populations. To do this well, the project must strive to elevate and support both MSM and TG leadership as well as TG-specific programming.
- While it is understood that the decision to curtail capacity building in FY 2018 was due to resource constraints, existing local implementing partners continue to need support, as will the two new partners being added this year.

- Although LINKAGES regularly organizes partner meetings, local partners would benefit from more opportunities to share lessons learned and engage in joint problem-solving.

4. Structural Interventions

Strengths

- LINKAGES has conducted valuable training for health workers to reduce stigma and discrimination towards KPs in health facilities. These trainings also included LINKAGES staff and MSPP representatives. LINKAGES/Haiti has initiated an effort to gather feedback on quality of services post-training through use of mystery clients representing different KPs.
- The project has trained police officers in some settings to strengthen the response to cases of violence and discrimination. Though not widespread, the training was an important start in sensitizing police to the stigma, discrimination, GBV, and harassment that many KPs face.
- LINKAGES/Haiti participated in a GBV study in three departments and has initiated a site-level GBV reporting system. Data from the study will be included in a multi-country publication on GBV and KPs, while ongoing reporting will also help characterize the nature and prevalence of violent incidents perpetrated against KPs. Improved reporting should also strengthen support and care for individuals who have experienced violence.
- LINKAGES/Haiti has produced two publications that highlight the voices of the country's LGBT communities. One gathered personal testimonies about LGBT lives in Haiti, while the other analyzed Haitian media coverage of LGBT populations, especially MSM.
- The project is working with traditional leaders (e.g., Houngans [male voodoo priests]) to reach KPs, especially MSM. Gender non-conforming people are generally more welcomed by voodoo practitioners than by the general population; consequently, increasing relationships with these key community leaders is an important way to connect with marginalized populations.

Challenges

- Systematic violence prevention and response (VPR) mechanisms are not well developed. Although LINKAGES/HQ and other country programs have developed resources to guide the development and functioning of site-specific VPR networks or Crisis Response teams, most partners in Haiti have not yet put such systems in place. Current violence response actions are almost exclusively medical and psychosocial, with little attention given to justice-seeking. Violence prevention is also not sufficiently addressed.
- Coverage of health workers, counselors, and health facility gatekeepers trained in KP-friendly approaches is insufficient within facilities. Although the training was considered to be useful, feedback from implementing partners suggested that coverage and frequency were not sufficient to effect lasting change, especially given the frequent turnover of facility staff. In addition, several of those interviewed suggested that other health facility "gatekeepers," such as administrative staff and guards, be included in future training to reduce stigma and discrimination.
- Community engagement to sensitize the general population about stigma related to HIV and to KPs is limited. Feedback from implementing partner staff and peer outreach workers suggested that more attention should be given to general community education, especially in neighborhoods or regions where DICs have been established or when outreach is conducted.

- FSW PEs noted that they do not necessarily know where they should refer adolescent girls and young women whom they meet during their outreach work. Note that only one partner, GHESKIO, is working with adolescent girls and young women and, in principle, these clients should be referred to public health facilities.

5. Strategic Information

Strengths

- LINKAGES/Haiti complies with the MSPP reporting system and data collection, with links to the national MESI system (Integrated Monitoring, Evaluation, and Surveillance). It has also developed data collection tools for effective registration, provision of services, referral systems, and individual tracking tools for peer outreach. Discussions are currently underway regarding the migration to the District Health Information System (DHIS) 2 platform for day-to-day monitoring.
- Systems to ensure quality of data collection and management are strong. The LINKAGES/Haiti strategic information team has provided considerable training and supervision to partners, and has conducted regular data quality audits to ensure data are clean. This includes de-duplicating indicator data for the last two fiscal years.

Challenges

- There is a lack of confidence in the MSM size estimations. MSM positivity rates and reach are lower than set targets in project sites, which raises questions about the validity of the targets and the population size estimates they are based on.
- LINKAGES/Haiti does not track clients who may be lost between an initial reactive test during community-based outreach and confirmation testing, which must be done at a static facility. Anecdotal information from partners indicated some concern that clients were not following through with confirmatory testing after an initial reactive test. Although the data are being captured, they are not being analyzed to determine whether or not this is a significant problem. Furthermore, the reasons for loss to follow-up among clients before treatment enrollment are not well understood, although several interviewees reported that treatment delay is likely due to a combination of factors, such as not being aware of the benefits of treatment, beliefs in witchcraft, fear of stigma, and concerns about confidentiality.
- Because the UIC does not extend to the care and treatment side of the cascade, it is difficult for implementing partners to track referred clients once they have a confirmed HIV diagnosis. This is a problem for the national HIV program in general. In addition, datasets from different service delivery points are not merged to track KP individuals across the entire cascade, and clients across databases in sites with multiple projects/partners are not yet de-duplicated.
- Yield of HIV-positive cases may be overestimated in some sites where the Global Fund Principal Recipient is mobilizing clients to seek confirmatory testing in LINKAGES sites. Specifically, at the FOSREF sites, with both LINKAGES and Global Fund/OHMASS support for KPs, the denominator in the LINKAGES data is “total tested by LINKAGES” plus clients with an initial reactive test from the Global Fund program, instead of number of clients tested through LINKAGES plus the number of people tested through Global Fund support. Therefore, the

denominator may be underestimated in the yield calculation and, as a result, the yield may be overestimated.

Evaluation Question 3: What are the constraints to successful implementation of the program?

- Due to available resources and USAID's geographic scope, the number of sites is limited and is insufficient to make a significant impact on reducing the KP contribution to Haiti's epidemic. Effectively engaging KPs in the national HIV epidemic response requires high-intensity and frequent intervention. While LINKAGES/Haiti has begun to show effectiveness, available resources limit the scope and coverage of critical elements, such as the creation of additional DICs and safe spaces, ongoing stigma and discrimination reduction efforts within public health facilities, and expansion of other structural interventions. LINKAGES/Haiti could consider other ways to expand the model, including partnerships with other funding organizations.
- Stigma and discrimination increases the vulnerability and marginalization of KPs. For example, Haitian society remains highly homophobic and transphobic, deterring members of the MSM and TG communities from seeking health services, including ART. Sex workers face challenges in accessing services, including violence and police harassment. The prominence of street gangs in Port-au-Prince makes it difficult to develop community support programs, including VPR activities. In addition, people from KPs who are living with HIV can be stigmatized within their own communities.
- Despite reassurances from the Procurement and Supply Management team at Chemonics in Port-au-Prince, which manages Haiti's PEPFAR-related commodities, implementing partners reported periodic shortages of condoms and ARVs, requiring them to "borrow" from other projects or sites to manage gaps. There were also unconfirmed reports from partners that they were restricting the number of condoms that PEs can take for outreach work, to avoid stockouts. However, LINKAGES reports that beneficiaries receive large quantities of condoms when there are no stockouts and that, as a result of micro-planning, beneficiaries receive condoms based on their needs for at least a month.
- Some national policies hinder program implementation. For example, new national norms have lengthened the interval for recommended HIV testing from three months to six months, although LINKAGES has successfully lobbied to maintain the three-month interval for KPs other than brothel-based FSW. In addition, national standard operating procedures prohibit community-based confirmatory HIV testing, which increases the risk of losing these clients before their tests can be confirmed at static facilities.
- Across Haitian society, mystical or spiritual beliefs regarding HIV hinder understanding of the epidemic. This contributes to frequent use of traditional or spiritual healers for alternative care, as well as high levels of denial and poor self-acceptance among those diagnosed as HIV positive, causing delays in testing and treatment-seeking.

Evaluation Question 4: How well does the project align with PEPFAR and OHA and global priorities and approaches?

The work of LINKAGES/Haiti is strongly aligned with PEPFAR and OHA global priorities and approaches, especially partnerships and work with KPs. The core PEPFAR and OHA commitment to

partnerships is a fundamental component of the LINKAGES work in Haiti. The project also has productive partnerships with the government at national and department levels and with CSOs.

The project's use of an expanded cascade to plan, implement, and measure its activities is also a clear reflection of its alignment with PEPFAR and OHA's commitment to epidemic control. LINKAGES acknowledges the importance of the 90-90-90/95-95-95 approach and objectives and their influence on its work.

In addition, the LINKAGES global and Haiti-specific focus on work with KPs is closely aligned with the priorities of PEPFAR and OHA. PEPFAR is very clear about its support for work with these populations, stating on its website: "PEPFAR stands firmly and unequivocally with key populations. These groups include gay men and other men who have sex with men, people who inject drugs, sex workers, transgender persons, and prisoners." The website is equally clear about one of the primary reasons for working with these populations: "In almost every country in the world, members of these populations are at greater risk for HIV than the rest of the population. Globally, these key populations account for 45 percent of new HIV infections, according to UNAIDS, although they make up a much smaller proportion of the total population."

III. Recommendations

As requested by the USAID Mission in Haiti, the recommendations are prioritized based on programmatic importance and likely feasibility.

Highly important

- **Review and implement programmatic size estimation (in addition to updating mapping) to establish more realistic targets.** Using PEs to regularly engage in operational size estimation and mapping, and use of online, phone, and social network mapping, could help better understand KPs, especially MSM, and the resources required for effective reach. This could be done as part of the broader exercise to revise hotspots and catchment areas. Applying lessons learned from other LINKAGES country programs, such as Malawi, which has developed an efficient and innovative approach to size estimation and mapping (i.e., the "Site Walk"), is also recommended. In addition, LINKAGES/Haiti needs to consider both how to reach FSW not reached through current sites and how to reduce support to FSW who may no longer need such intensive services.
- **Continue to improve tracking of clients who move from prevention to treatment at project and non-project sites.** This could include further strengthening the UIC system by sensitizing beneficiaries to its importance, as well as expanding the system to the Global Fund KP partner and to other districts, to facilitate tracking of KPs who are mobile, as well as de-duplicating individual-level data among partners that are co-located. In this regard, employing one data manager within a site who would be focused on managing multiple databases from different donors/partners would be useful. Linking the KP tracking system with the ART tracking system would enable tracking across the cascade. Another suggestion is standardizing indicators, data collection tools, and reporting periods across donors and partners to track progress toward UNAIDS 90-90-90 goals at the national level.
- **Analyze data to better understand the reasons why clients are lost to follow-up at each step in the prevention and treatment cascade.** Currently, the project does not

sufficiently analyze the factors contributing to losses to follow-up. This includes analyzing available data on the proportion of reactive clients lost before confirmatory testing.

- **Strengthen structural interventions related to violence prevention and response.** Currently, LINKAGES/Haiti's implementation of structural interventions is at an early stage. Greater attention should be given to establishing and strengthening violence/crisis response teams and improving access to legal support. It would also be useful to promote increased involvement of the police, community, and religious leaders through increased sensitization trainings and engagement in KP-related community forums. Leveraging partnerships with human rights and GBV stakeholders (e.g., Konbat Vyolans, the Justice Sector Strengthening Project) to address KP vulnerability to violence and human rights violations is also recommended. Expanded training on provision of non-stigmatizing and non-discriminatory HIV services is also needed, with emphasis on training entire teams on clinical competencies (e.g., treatment of anal warts).
- **Review strategies to motivate and retain PEs and PNs.** These cadres are essential to the success of LINKAGES in Haiti. It is crucial, therefore, to ensure that their needs are met by providing, for example, additional training, adequate transport stipends, and psychosocial support (particularly for PNs). LINKAGES could also assess the value of other initiatives, such as food supplements or hygiene kits that could be used to engage clients. LINKAGES should engage with other PEPFAR programs and the Global Fund to ensure that incentives and support for PEs and PNs are consistent.
- **Implement innovative outreach strategies to access harder-to-reach, hidden, and never-tested KP individuals, including extending use of EPOA to other sites.** As part of this effort, LINKAGES should develop strategies for reaching informal and non-brothel based FSW, MSW, and TG populations.
- **Capacity development and its evaluation (OPI) should continue for all local implementing partners.** This should include efforts to increase the number of KP-led partners, and promote KP leadership within non-KP-led partners.

Important

- **Advocate for the placement of a KP point person within PNLS.** The national program and LINKAGES/Haiti would benefit from having a designated KP focal point at PNLS. This would also help the government to institutionalize its strategic commitment to addressing KP needs in the country's national HIV epidemic response. The responsibilities of the focal point could encompass structural interventions and capacity building among other issues.
- **Strengthen collaboration and data-sharing at the department level.** Routine meetings to review results and discuss strategies and coordination, as well as sharing of monthly site reports, are recommended to improve collaboration.
- **Improve intra- and cross-project learning among implementing partners, non-project partners, and other LINKAGES country programs.** LINKAGES/Haiti should capitalize on the strengths and complementarity of local partners to improve collaboration and joint tracking of common clients (e.g., CPFO and SEROVie contribute to testing/treatment enrollment at GHESKIO). Improved coordination with non-project partners, such as the Global Fund and with LINKAGES' work in other countries, would also enrich learning and quality improvement.

- **Investigate and address the low uptake of PEP among FSW who experience sexual violence.** Some FSW who had experienced sexual violence and who were familiar with PEP reported that they had not received it. This needs to be verified as those who experience sexual violence should receive PEP within 72 hours.

The LINKAGES/Haiti project is highly appreciated among all partners and, despite a slow start, it has the potential to accelerate the country's efforts in reaching the 90-90-90 targets and achieving epidemic control. The project is gaining momentum with clear improvements in reach, yield, and treatment initiation. If the project can act on these recommendations, its effectiveness will be further strengthened. It is important that technical and financial support be continued for the remaining project term.

KENYA COUNTRY REPORT

I. Introduction

LINKAGES/Kenya has achieved remarkable success in a relatively short time by delivering a comprehensive, multifaceted package of interventions for key populations (KPs), with a focus on female sex workers (FSW) and men who have sex with men (MSM). The project has helped Kenya's National AIDS and sexually transmitted infection (STI) Control Program (NASCOP) elevate and sharpen its focus on KP programming by bringing relevant, innovative biomedical, behavioral, and structural interventions. Building on previous USAID investments in Kenya, LINKAGES is successfully leveraging and strengthening capacity of local implementing partners so that these organizations can provide high-quality services across the expanded prevention, care, and treatment cascade. LINKAGES/Kenya has also contributed to the emergence and strengthening of new KP-led organizations. In addition, innovative structural interventions focusing on violence prevention and response (VPR), and stigma and discrimination, as well as the establishment of drop-in centers (DICs), have improved KP access to and acceptability of services.

The coverage of LINKAGES activities and, consequently, their impact, is limited due to resource constraints. However, despite this, LINKAGES/Kenya has implemented a diverse range of interventions and reached large numbers of KPs, demonstrating that the model works and providing a strong case for scale up to achieve sustained impact.

II. Findings by Evaluation Question

Evaluation Question I: How effectively is the project achieving its goals and objectives?

LINKAGES/Kenya has made impressive progress in its two years of operation. As shown in Table I, there were solid increases in performance across the key PEPFAR indicators between FY 2016 and FY 2017. After coming close to meeting the key PEPFAR targets among MSM/TG for KP_PREV and HTS_TST in FY 2016, LINKAGES/Kenya exceeded both in FY 2017, including a 221% achievement against target for KP_PREV.

There has been a decline in HTS_TST among FSW. Testing yields are low, particularly among FSW. This is most likely due to the low numbers of new infections among KP. Low yields do, however, reinforce the potential value of introducing the Enhanced Peer Outreach Approach (EPOA) and other approaches to increase the effectiveness of targeting in Kenya.

Table I. Indicator Performance, including percent change between FY 2016 and FY 2017, testing yield and treatment uptake

Core Indicators	FSW			MSM		
	FY16	FY17	% change	FY16	FY17	% change
KP_PREV: Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	47,614	62,418	+31%	9,787	15,823	+62%
HTS_TST: Number of KP who received HIV Testing and Counseling (HTS) services for HIV and received their test results	24,378	33,022	+35%	4713	7,851	+67%

Core Indicators	FSW			MSM		
	FY16	FY17	% change	FY16	FY17	% change
HTS_TST_POS: Number of KP tested HIV positive (testing yield)	486 (2.1%)	720 (2.2%)	+48%	167 (3.5%)	321 (4%)	+92%
TX_NEW: Number of KP newly initiated on antiretroviral therapy (uptake)	388 (80%)	567 (79%)	+46%	117 (70%)	237 (74%)	+103%

Although the rate of antiretroviral therapy (ART) uptake is also low, LINKAGES/Kenya has achieved a significant improvement in TX_NEW among FSW and was able to meet its TX_NEW target for MSM/transgender (TG) in both FY 2016 and FY 2017 (Table 2).

Table 2. Indicator Performance against fiscal year targets

Core Indicators	FSW		MSM/TG	
	FY16	FY17	FY16	FY17
KP_PREV	105%	118%	93%	221%
HTS_TST	107%	78%	90%	137%
TX_NEW	9%	67%	100%	109%

Evaluation Question 2: What are the project's strengths, weaknesses, and/or gaps in planning, management, service delivery, and sustainability?

I. Management and Oversight

LINKAGES/Kenya maintains a core technical and management team in Nairobi at the FHI 360 offices, with Senior Program Officers based in the counties where the project is active. The Kenya team receives technical support and input from LINKAGES headquarters in Washington, DC, primarily in the form of standardized curricula, guidelines and Standard Operating Procedures (SOPs); strategic information and monitoring and evaluation (M&E); and documentation and dissemination.

Strengths

- The LINKAGES/Kenya team is highly experienced, with strong technical, clinical, managerial, financial and administrative expertise. Leadership and technical staff have good relationships with the national and county-level Ministry of Health/NASCOP teams, LINKAGES core partners, local implementing partners, and other USAID partners, such as those implementing APHIAplus and follow-on projects.
- LINKAGES/Kenya has forged strong, positive relationships with government partners and contributed to improvements in the national response to HIV. LINKAGES is effectively building on previous USAID/PEPFAR investments, most notably previous APHIA programming and follow-on mechanisms. Through LINKAGES, critical, targeted technical support to County AIDS and STI Coordinators (CASCOs), County Health Management Teams (CHMTs), as well as NASCOP, has accelerated alignment with the National AIDS Strategic Framework (NASF). By aligning its tailored package of services with the NASF and NASCOP's SOPs – the development of which were supported by LINKAGES/Kenya – the project has successfully added community

participation and community-based models of care to the paradigm for controlling the epidemic. It has also played an important role in encouraging the National KP Program to adopt the LINKAGES Unique Identifier Code (UIC) approach. These approaches hold great promise for accelerating the Kenyan HIV response among KPs.

- LINKAGES has used a multi-level, integrated approach to coordinate, liaise, and leverage resources and structures from the bottom-up and top-down. The project has supported the National Key Populations Technical Working Group (KP TWG), and has been instrumental in establishing and supporting several County KP TWGs and sub-county advocacy committees. This has enabled the project to effectively support national and county stakeholders to standardize approaches, share best practices, agree on course corrections, and strengthen local, county, and national partnerships, with a focus on improving coverage and quality of HIV-related services and information for KPs. These management mechanisms also ensure that key features of project implementation are consistent with and reinforce NASCOP policies and guidelines.
- Through its partnership with the University of Manitoba, whose staff are embedded within the Technical Support Unit (TSU) to provide technical assistance to NASCOP, and with the Government of Kenya, LINKAGES/Kenya has played a significant role in informing, standardizing, and codifying critical SOPs and guidelines that are aligned with global best practice and national policy. Specifically, LINKAGES supported the production of six documents,¹¹ now included as NASCOP's officially endorsed guidance on KP programming for the country's HIV response. This collaboration has helped position NASCOP as a progressive leader, while LINKAGES/Kenya, through its project partners, ensures that implementation is consistent with the guidelines and SOPs. This cycle of design, implementation, feedback, and revision appears to function well.
- LINKAGES/Kenya has 18 in-country partners, which support 25 DICs in 16 counties. About 70% of FY 2017 funds were allocated to implementing partners, reflecting the project's focus on strengthening local NGO capacity. Although the overall annual budget (\$3.9 million in FY 2017) is modest relative to the project's scope, the management team, as well as county-based staff and partners, has a strong collective commitment to maximize the use of limited resources.

Challenges

- Reaching the PEPFAR targets requires a range of activities and repeated contacts that are not captured or reflected in project indicators or reporting. Improving HIV-related prevention, testing, treatment, and retention among KPs generally requires more intensive and sustained efforts than comparable work with other populations, in part due to stigma, discrimination, and marginalization. The pressure to reach PEPFAR targets can result in a focus on a narrow set of activities rather than on the full range of activities necessary to meet them. Achieving an appropriate balance is a challenge for project management.
- Current resourcing is insufficient to move to significant scale-up. The LINKAGES/Kenya team continues to expand coverage where possible, but funding remains the same or has diminished for some partners. Unit costs per KP reached appear to be low given the targets, with a

¹¹ 1) GBV Training Manual for Health Care Providers; 2) Standard Operating Procedures for Establishing and Running Key Populations Clinics in Kenya; 3) Standard Operating Procedures for Establishing and Operating Drop-in Centers for Key Populations in Kenya; 4) Handbook to Train Peer Educators-FSWs; 5) Manual to Train Peer Educators-MSM; and 6) Manual to Train Peer Educators-FSWs.

misalignment in unit cost estimates between the Government of Kenya and PEPFAR (\$115 vs \$43 per KP). There is no accounting or quantification of investments provided by the volunteer peer outreach workers on which the success of programming rests. A better assessment of costs is needed.

2. Delivery of HIV-related Services

LINKAGES/Kenya argues that, as Kenyan citizens, KPs should claim their right to health care through the government system. However, stigma, discrimination and, on occasion, refusal of services, are pervasive in public health services, creating significant losses to follow-up throughout the HIV cascade. Given this context, it is not surprisingly that staff, peer educators (PEs), peer navigators (PNs), and clients at DICs visited by the evaluation team expressed the need for DICs to expand the range of services they offer for KPs. Implementing partners, PEs, and beneficiaries also emphasized that providing only HIV testing services (HTS) at DICs offered little advantage over conventional service delivery, with a majority of beneficiaries noting that they do not feel comfortable accessing government HIV services. Until public health services are more KP-friendly and responsive, provision of a comprehensive range of HIV and related prevention, care, and treatment services for KPs through DICs and other service delivery models may be warranted in the interim.

Strengths

- PEs are well trained and supervised to provide a comprehensive mobilization package and are highly committed to their work. The mobilization package includes condom and lubricant distribution, health education and behavior change messaging, and referral for HTS, during outreach and at DICs. Evaluation team site visits suggest that PEs have a strong command of project tools, such as those used to undertake micro-planning, document enrollment, record PE encounters and develop peer plans, track health education sessions and HTS referrals, and identify and refer clients experiencing violence. Peer mobilization and behavior change efforts are complemented in many cases by information and communication technology (ICT)-based approaches to reinforce key HIV prevention messages, support violence prevention and response, and promote treatment adherence. PEs use platforms, including WhatsApp and Facebook, as well as radio and TV. During FY 2017, 10 PEs were trained as master trainers in pre-exposure prophylaxis (PrEP), referral for which was added to the mobilization package in FY 2017 in collaboration with Jilende.
- LINKAGES/Kenya's approach to establishing DICs has been standardized and is documented in SOPs that have been endorsed by NASCOP. The adoption and implementation of DIC-related SOPs and guidelines, if scaled-up, has the potential to accelerate NASCOP's effectiveness in reaching and providing services to KPs throughout the country. Sites visits to nine DICs in four regions indicated that, in all cases, DIC SOPs were being operationalized, with some variation in range of services offered and the degree of collaboration with nearby government health facilities. These variations reflect the maturity of the implementing organization and duration of funding; for example, some DICs only opened during FY 2017. A key feature in all settings is the development of a referral directory to link community outreach and mobilization activities with service delivery points that offer KP-friendly services.
- The combined use of outreach and safe space approaches has resulted in significant, year-on-year increases in reach and testing. About 70% of enrolled KPs access HTS at hotspots and 30% at DICs. The ability to confirm HIV-reactive results in outreach and DIC settings is also an

important best practice. Intensive weekly health education and HIV prevention dialogues and targeted outreach methodology were also introduced in FY 2017 to accelerate HIV testing uptake and especially case-finding among MSM and FSWs. Other populations are or will soon be targeted as well: more than 8,000 male sex workers were identified in FY 2017, with plans to tailor outreach and care for transgender populations in the remaining project years.

- LINKAGES introduced a UIC system for the prevention and care elements of the cascade, which is being adopted by DICs and endorsed by NASCOP (the UIC is not currently used for tracking ART at health facilities). The system has improved the ability of partners and affiliated DICs to track clients through prevention and testing interventions, and there have been some efforts to combine patient identification numbers within government services with the LINKAGES-supported UIC system.
- LINKAGES/Kenya is thoughtfully considering the balance of clinical services that should be provided at DICs. Most of the 25 DICs established thus far focus primarily on HTS and provision of a basic clinical package (TB screening, STI and cervical cancer screening, gender-based violence (GBV) screening, family planning, post-exposure prophylaxis (PEP) and, in some settings, PrEP). Some have been able to expand the array of care to also include ART dispensing, STI treatment, and antibiotics for opportunistic infections, and these have been appreciated by clients as a step towards a one-stop shop approach.
- The project is successfully implementing client-centered, KP-responsive service delivery approaches. The training and deployment of PEs – and, for clinical follow-up, PNs – is critical to gaining the trust of and supporting service access and follow-up. The regular convening of clinical and outreach team meetings and training on how to better link clinical and outreach services both within DICs and at public health facilities is also a key strength. Supportive supervision is being provided by government health workers to DIC-based and outreach clinicians to ensure quality and build relationships with public health providers.
- PNs are well-prepared and invested in the LINKAGES model. Regardless of the balance of services offered, it is clear that the PN role is vital to the success of the LINKAGES model. PNs essentially serve as case managers for clients identified as HIV positive. They accompany clients referred to public HIV Comprehensive Care Centers (CCCs) or other facilities for confirmatory testing and care and treatment services, liaising with facility “Link Desks.” They are also responsible for follow-up, ensuring adherence, tracking clients who have interrupted treatment, and attending to other needs, such as psychosocial support. In addition, they are responsible for documenting the referral process and follow-up efforts and are trained to encourage HIV-positive clients to disclose their status to their partners.
- Strong relationships between DICs and health facilities are leading to better retention. While more evidence is needed on reach, yield, retention, and viral suppression, preliminary data from several sites suggest that where DIC-based and outreach clinical services are closely coordinated with and supported by government services and structures (CASCOs, CHMTs, and local CCCs), enrollment and retention rates may be better. The examples that the evaluation team saw at several sites – for example at FAIR in Nakuru and Rongai and at K-NOTE in Navaisha – suggests that having DICs serve as satellite sites to public health facilities would be the most effective approach, as this creates and maintains strong referral and follow-up links with CCCs or other health facilities.

- STI screening, diagnosis, and treatment are important entry points for KPs. DIC clinical staff and staff at referral facilities have been trained on clinical management of STIs, and the availability of STI treatment services and drugs has improved retention of clients at DICs. Due to chronic shortages of STI drugs in Kenya, LINKAGES/Kenya has established a separate supply chain for free STI drugs at DICs with support from USAID.
- LINKAGES/Kenya is working with community-based distribution points to expand provision of ART to KPs. In addition, the project is supporting implementing partners to accurately forecast, quantify, and distribute condoms and lubricants to avoid stockouts.
- The comprehensive approach to service provision is also central to DIC service delivery. In addition to structural interventions addressing violence prevention and response and stigma reduction, many DICs also are providing psychosocial support and ART adherence counseling. In some, drug and alcohol abuse counseling and legal support are also provided; the demand for these services exceeds the project's capacity to deliver them.

Challenges

- Testing yield is low given the estimated burden within the country, with only 2.5% KPs testing HIV positive in FY 2017, and TXT_NEW numbers fall short of current targets and have not increased over time. These may be attributable, in part, to insufficient resources to expand the number and scope of services provided at DIC sites. Criminalization of KPs is also a challenge, as is stigmatization and discrimination within public health facilities. Consequently, some of the most at-risk KPs may not be reached by current approaches. Couple testing is also very low, which is problematic given that PNs report that KPs fear disclosing their status to their partners if they test positive.
- The project has a high turnover among PEs. Monthly stipends to cover transport fees are reportedly insufficient, with PEs running out of funds halfway through the month.
- As LINKAGES/Kenya is not funded to target these populations, there are no efforts to map or target people who inject drugs (PWID), transgender (TG) populations, or clients of FSWs.
- The limited range of clinical services provided at some DICs results in drop-out of some clients referred to government facilities. Many clients expressed the desire for a “one-stop shop” approach that includes minor surgery for anal warts, laboratory services, ART administration, and primary health care for children of KPs.
- Follow-up of clients enrolled in prevention and testing through PEs is challenging, especially when they have to be referred to public health facilities for clinical care. Since only five of the 25 DICs currently provide ART onsite, HIV-positive clients must go to other facilities for treatment, where the LINKAGES UIC system is not in place and where the project has little influence. Many are reported to travel outside of the LINKAGES catchment areas to retain anonymity, while others change their names. Clients counted as having dropped out or interrupted treatment, therefore, may be on treatment but not trackable. In addition, there is no standardized system for tracking referred clients through care and treatment within public health facilities and CCCs unless specific arrangements to share records have been made. Ongoing national discussions on the use of biometric tracking for KPs, which poses risks related to violations of privacy and human rights, have slowed implementation of other solutions for tracking KPs through the cascade outside the project.

- While the project recognizes the diversity of KP needs based on factors such as socio-economic status, sexual orientation, gender identity and expression (SOGIE), some sites are still combining interventions and safe spaces for MSM and FSWs, mainly due to resource constraints. In many cases, this is not ideal, as MSM, in particular, would prefer their own spaces.
- LINKAGES/Kenya is not systematically investigating and documenting the reasons for drop-out or loss to follow-up, information that could be used to improve tracking and retention.

3. Community and Civil Society Engagement

Strengths

- An important element of the LINKAGES model is its focus on building capacity of local community-based organizations, especially those that are KP-led, so that they can contribute to the epidemic response. LINKAGES/Kenya is enhancing the capacity of existing community-based partners, none of which had provided clinical services before, as well as facilitating the creation of new KP-led service organizations (e.g., MPEG in Kiambu). In doing so, the project is successfully creating a cadre of KP organizations that can implement a comprehensive KP service package in line with national guidelines and developing a foundation for expansion in the future. This is enabling KP-led organizations to gain legitimacy, credibility, and a collective voice in Kenya to ensure that the needs of their communities are addressed in the country's HIV response. It is a good example of putting the slogan "Nothing about us without us" into action.
- A key strength of the project is the focus on KPs in leadership and management roles. Seven of the 18 local implementing partners (five MSM and two FSW organizations) in Kenya are KP-led and managed; two non-KP-led organizations are elevating the roles of KPs within their management and leadership ranks. Community Advisory Boards have been established for each implementing organization. These are made up of five to seven people, including KPs, who provide input and guidance on programming to the partner in their catchment area(s).
- Local implementing partners appreciate project support for management and technical capacity strengthening, including the use of the Integrated Technical Organizational Capacity Assessment (ITOCA) and Organizational Performance Index (OPI) processes. There have been clear, measurable changes (per the OPI) in capacity across all organizations receiving support.
- Many community-based partners have also been able to secure funding for related work from other organizations, as a result of the increased capacity they have developed through LINKAGES. A number of groups (e.g., MAAYGO, KASH, HOYMAS, ICRH) were selected as partners for the Jilinde Project to introduce PrEP. Several have also accessed funds from the Open Society Foundation, the Global Fund, and UHAI.
- LINKAGES/Kenya has created a platform for implementing partners to share performance, best practices, challenges, and learning experiences. Peer volunteers are asked to provide inputs on their experience of project activities and, for example, what they have learned about effective messaging for PEP, PrEP, condom, and lubricant use. Four e-bulletins on LINKAGES' approaches and outcomes were also distributed outside of the project.

Challenges

- Implementing partners would like further support, for example, for business planning and management skills as well as to develop basic research capacity, but this is not included in current project plans due to resource constraints.

4. Structural Interventions

- The LINKAGES health worker training package to reduce stigma and discrimination has been adapted for Kenya. Training has been well received, with demand for additional coverage. LINKAGES/Kenya has also worked with facilities to develop policies and procedures to reduce stigma and discrimination and to provide coaching as well.
- LINKAGES/Kenya has developed a VPR acceleration approach, specific to FSWs and MSM, which is aligned with the National Manual on Violence. The approach includes hotlines, paralegal staff, crisis response teams, and a GBV early warning system with GBV cases reported to WhatsApp groups. PEs, health workers, the police, and community and religious leaders have also been trained on GBV issues using the new national training manual, and 26 crisis response trainers have been prepared. In Mombasa, an “Election Preparedness and Mitigation Plan” was developed to prevent post-election violence and disruption of services.
- LINKAGES/Kenya actively supports rights-based approaches, with a focus on recognition of the rights to health and privacy as the basis for improving access. This reflects a good understanding that much of the stigma and discrimination faced by KPs is related to gender, sexual orientation and expression, and profession; for example, sex work, rather than HIV status. KPs are encouraged to report stigma and discrimination experienced at health facilities to their DIC; DIC clinicians then engage with staff at the facility to sensitize them to the needs and rights of KPs.
- LINKAGES/Kenya has provided training and sensitization to the police on the rights of KPs and the importance of reducing stigma and discrimination. As a result, the police have become important partners in most sites, with an especially strong collaboration seen in Kisumu. Police are generally part of DIC-based violence prevention and response networks and provide protection during peer outreach. Access to justice through legal service support using paralegals is also available in some settings.
- Despite limited resources, LINKAGES/Kenya provides some support to address other underlying determinants of HIV risk. For example, KASH in Kisumu has an alcohol and drug counselor. In several sites, LINKAGES is providing advice on development of micro-enterprise activities, such as group savings and income generation (e.g., a carwash service in Mombasa).

“If you are not dealing with violence, you are not doing anything. When I am safe, I can protect myself.” – Peer Educator, Mombasa

“The question should be ‘How do we make structural interventions more effective?’, not whether to have them.” – NASCOP Technical Support Unit, Nairobi

Challenges

- Although the project’s structural interventions have been valuable, many KPs continue to face human rights violations, stigma, and discrimination, and additional efforts and resources are needed to effect long-lasting change. Cases of GBV are still under-reported. Health worker

training has not been able to cover all relevant staff and its effectiveness is lessened due to frequent staff turnover. The Kenyan Human Rights Commission is not yet involved in LINKAGES VPR work with KPs and the role of Kenya Sex Workers Alliance is unclear. Coverage of interventions involving the police also need to be expanded to achieve and sustain real change. Other structural interventions, such as drug and alcohol services, legal services, economic empowerment, and parenting support, could all be useful entry points to increase reach and engagement of KPs and, hence, to increase KP access to HIV-related services.

- LINKAGES has not developed a systematic approach to evaluating the effectiveness of training health workers on reducing stigma and discrimination experienced by KPs in public health facilities. Regarding violence, the new GBV-related indicators were not yet being used.

5. Strategic Information

Strengths

- LINKAGES/Kenya continues to strengthen the capacity of local implementing partners through mentoring and coaching to collect, manage, and use key data, including the use of a dashboard and data quality assessments to improve data quality and use of a UIC. Partners are also disaggregating data by age and new/repeat testing. Micro-planning and cascade monitoring at the site level have been critical to performance improvements, including moving to new hotspots, tracking reach and yield by location and KP group, and identifying clients potentially lost to follow-up. This was evidenced by the Kuja Clinic campaign, which took a systematic approach to increasing the numbers of KPs accessing clinical services, through micro-planning and peer analysis to identify hotspots and individuals who have not accessed services and then target them with outreach and mobilization activities. Implementing partners have also been trained in the use of the new custom indicators. Data are being used to guide programming by PEs and PNs and at DIC, county, project, and national levels. At the end of FY 2017, LINKAGES/Kenya started strengthening routine monitoring and supportive supervision, increasing the focus on partners reporting low yield and HIV testing rates, links to HIV care, and tracking of the 90-90-90. Online mentorship for implementing partner staff is also available upon request.
- The project collaborates with NASCOP via the TSU, which conducts monthly supportive supervision and routine data quality assessments. The KP TWG acts as an advocacy platform that recommends improvements based on county-level experience. The project database is updated quarterly to adjust planning and improve strategies, in coordination with the KP TWG. In February 2017, monitoring and evaluation (M&E) tools were updated and included the development of a template with new indicators to improve harmonization with NASCOP. Migration to the District Health Information System (DHIS) 2 platform is underway, and data have been de-duplicated, enabling implementing partners to follow individuals. Data on KPs who have been tested vs. re-tested have been disaggregated, and male sex workers have been disaggregated from MSM.

“We are learning how to use data – and discussing and planning. This is totally different than before. It is helping us grow.” –Peer Educator, Nakuru

Challenges

- National KP size estimates, which are the basis for the LINKAGES targets, should be reviewed and possibly updated using a methodology relevant for strategic and operational planning. Clarifying these estimates at the county level with an appropriate, cost-effective methodology would enable LINKAGES to better quantify its actual coverage and assess its capacity to expand.
- The mandatory M&E approach that LINKAGES uses is not sufficiently aligned with Kenyan national indicators.
- LINKAGES metrics do not measure processes or factors that influence performance, which could help to improve understanding of what does and does not work and to identify best practice.

Evaluation Question 3: What are the constraints to successful implementation of the program?

- The primary constraint is insufficient resourcing, with available funding spread too thin, leading to missed opportunities for impact. Effectively engaging KPs in the national HIV response requires high-intensity, frequent intervention, especially at the start. While LINKAGES/Kenya has been remarkably effective despite resource constraints, limited funding has prevented the project from implementing interventions at the scale and intensity required to maximize impact and from extending interventions to address the needs of other KPs.
- While not often enforced and currently under legal challenge, Kenya's anti-sodomy law legitimizes pervasive societal homophobia and transphobia and also fuels self-stigma. As a result, many people are reluctant to use, or are driven away from, HIV services, and are effectively denied the rights to health care to which they are entitled as Kenyan citizens. Unsurprisingly, it has been most difficult to reach targets in areas of the country where stigma and discrimination towards MSM are greater. Violence towards sex workers has historically been so pervasive that it has been normalized, and FSW themselves need to be sensitized to the definitions of violence. In addition, sex workers are frequently targeted by the police and subjected to blackmail and abuse, and have few avenues for pursuing justice. Indeed, violence historically has been so pervasive that it has been normalized, so that sex workers themselves need to be sensitized to the definitions of violence.
- Government policies have affected implementation. One of Kenya's original partners, the Gay and Lesbian Coalition of Kenya withdrew from the project as it was unwilling to abide by current US government policy. More recently, LINKAGES has had to suspend some project activities due to US government restrictions on Government of Kenya involvement, and to stop activities involving PNs due to concerns raised by NASCOP.
- In all counties where LINKAGES/Kenya is active, there are chronic shortages of STI drugs. This has required the project to establish a separate supply chain for needed medications.
- As is the case in many countries and programs, the lack of a common UIC that spans prevention and treatment and care makes tracking of clients across the cascade difficult, and this is exacerbated by the variable degree of coordination with primary health facilities and CCCs across sites.

Evaluation Question 4: How well does the project align with PEPFAR and OHA and global priorities and approaches?

The work of LINKAGES/Kenya is strongly aligned with PEPFAR and OHA global priorities and approaches, especially partnerships. The core PEPFAR and OHA commitment to partnerships is a fundamental component of the LINKAGES work in Kenya. The project also has productive partnerships with government at national and county levels and with civil society CSOs. There are, however, some misalignments at the national level:

- The estimated unit costs per KP are not aligned, with the Government of Kenya estimated unit cost of \$115 per KP, vs. \$43 per KP estimated by PEPFAR. The planned cost analysis to be undertaken by the Mexico National Institute of Public Health with funding from the Bill and Melinda Gates Foundation will be very helpful in providing more information about unit costs.
- Current PEPFAR indicators do not align with Kenyan national indicators in all cases. This is noted, in particular, regarding the testing approach (universal testing vs. efficiency testing) and frequency of reporting (quarterly vs. annual reporting), which creates an additional management burden for the LINKAGES/Kenya team.

The project's use of an expanded cascade to plan, implement, and measure its activities is a clear reflection of its alignment with PEPFAR and OHA's commitment to epidemic control. LINKAGES acknowledges the importance of the 90-90-90/95-95-95 approach and objectives and their influence on its work.

LINKAGES global and Kenya-specific focus on work with KPs is closely aligned with the priorities of PEPFAR and OHA. PEPFAR is very clear about its support for work with these populations, stating on its website: "PEPFAR stands firmly and unequivocally with key populations. These groups include gay men and other men who have sex with men, people who inject drugs, sex workers, transgender persons, and prisoners." The website is equally clear about one of the primary reasons for working with these populations: "In almost every country in the world, members of these populations are at greater risk for HIV than the rest of the population. Globally, these key populations account for 45 percent of new HIV infections, according to UNAIDS, although they make up a much smaller proportion of the total population."

III. Recommendations

Overall, the review team was deeply impressed with LINKAGES/Kenya, and the team's topline recommendation is to continue to invest in this important project.

- **Identify and implement additional strategies to strengthen partnerships between public health facilities and DICs.** LINKAGES has shown that these partnerships can improve the quality and availability of services for KPs. These partnerships also leverage the relative strengths of the public health sector and DICs, making it easier and more efficient to provide KP-friendly services. It appears that where DICs have strong and formalized relationships with surrounding health facilities (as in Nakuru), the ability to link newly HIV-positive clients to treatment and track them through the care and treatment cascade is improved.
- **Consider how an adapted version of EPOA could be applied in Kenya.** EPOA is an effective, high-yield approach to HIV case finding, but because this approach provides financial incentives it is not aligned with current National KP Guidelines in Kenya. However, LINKAGES

needs to find creative ways to adapt and use this approach in the Kenyan context, especially with MSM, male sex workers, and TG populations, including mapping of new virtual and physical hotspots where KPs at especially high risk of HIV may be found through highly networked peers or “seeds.”

- **Accelerate and expand stigma reduction and VPR-related interventions, especially ones focused on health care workers and police.** The work in this area in Kenya is exemplary and should be expanded. The Nakuru/Navaisha experience with VPR community networks is a good example of a strategy that should be scaled up. LINKAGES/Kenya has forged important collaborations with the local police, for example, in Kisumu, and this experience should be documented and shared with relevant stakeholders, including implementing partners and county-level police officers and leadership.
- **Modify and simplify data-use tools (e.g., dashboards) to make them more usable at the site level for planning and programming in real time.** Enabling the use of the dashboard in real time, by site, would allow more immediate analysis of cascade data and adjustments in planning and targeting.
- **As resources allow, build capacity for and conduct operational research to enhance planning and learning.** Local partners have requested additional support to develop their capacity to conduct basic operational research as well as diversifying support provided to PEs. LINKAGES should consider support for this as part of a plan to implement operations research that would improve population size estimates, targeting, coverage, and performance. This approach would both build sustainable national capacity and generate important evidence for national and program use. Analysis of spending and per capita cost data would also be valuable for planning and performance monitoring; there are also potentially useful lessons to be learned from the way in which LINKAGES/Kenya has allocated available resources, in particular its strong focus on prioritizing funding of grassroots level implementation.

LAOS COUNTRY REPORT

I. Introduction

The LINKAGES project in Laos is small, but it is having an outsized effect on the HIV response for men who have sex with men (MSM) and transgender (TG) populations. In a national environment where HIV-related stigma and discrimination remains high, LINKAGES and its partners have shown how to effectively deliver HIV services to these populations. Key officials within the Ministry of Health (MOH) and its Centre for HIV/AIDS and STI (CHAS) recognize and understand the importance of working closely with these populations and providing services in non-stigmatizing and non-discriminatory ways. In fact, the government would like to see LINKAGES scale up its services beyond the limited number of provinces/districts/sites where it is currently operating. LINKAGES/Laos is struggling with HIV case detection; however, overall, the project is showing encouraging retention across the cascade.

II. Findings by Evaluation Question

Evaluation Question 1: How effectively is the project achieving its goals and objectives?

LINKAGES has helped government and civil society organizations (CSOs) in Laos improve their ability to individually and collectively plan, deliver, and optimize HIV prevention and treatment programs for key populations (KPs), including MSM, male sex workers, and TG populations.

The overall effectiveness of the LINKAGES approach in Laos is reflected in double-digit improvements in performance between FY 2016 and FY 2017 as well as performance against the key PEPFAR targets. LINKAGES also had strong testing yields in FY 2016 (6.4%) and FY 2017 (6.5%). Performance on antiretroviral therapy (ART) uptake should be better but there was significant improvement in FY 2017, increasing to 81.6% from 54.7% in FY 2016.

In addition, LINKAGES/Laos is performing well on two additional PEPFAR indicators: TX_RET and TX_PVLS. The FY 2017 target for TX_RET was 90% of HIV-positive MSM and TG known to be on treatment 12 months after initiation of ART, and LINKAGES achieved 88%. The FY 2017 target for TX_PVLS was 90% of MSM and TG on treatment and having a suppressed viral load, and LINKAGES again achieved 88%.

Table 1. Indicator Performance, including percent change between FY 2016 and FY 2017, testing yield and treatment uptake

Core Indicators	MSM/TG		
	FY16	FY17	% (+/-)
KP_PREV: Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	3,280	4,174	+27%
HTS_TST: Number of KP who received HIV Testing and Counseling (HTS) services for HIV and received their test results	2,487	3,163	+27%
HTS_TST_POS: Number of KP tested HIV positive (testing yield)	159 (6.4%)	207 (6.5%)	+30%
TX_NEW: Number of KP newly initiated on antiretroviral therapy (uptake)	87 (54.7%)	169 (81.6%)	+94%

Table 2. Indicator Performance against fiscal year targets

Core Indicators	MSM/TG	
	FY16	FY17
KP_PREV	183%	94%
HTS_TST	185%	93%
HTS_TST_POS	No data	118%
TX_NEW	310%	244%

In the nine districts of Vientiane Capital, two districts of Savannakhet province and two districts of Champasak province where LINKAGES/Laos is active, the combination of infrastructure and services provided by government and civil society partners has contributed to improvements in the quality and availability of support and assistance for KPs. The integrated model of service delivery that has been supported by LINKAGES (i.e., a combination of outreach activities, hybrid drop-in center/clinic, links to other relevant services, and ongoing case management) is seen as highly effective by experts in the MOH. There is also agreement among core stakeholders that the model demonstrates a strong proof of concept, which could have a far greater impact on the HIV response in Laos if it was taken to scale with additional donor or domestic funding.

Evaluation Question 2: What are the project’s strengths, weaknesses, and/or gaps in planning, management, service delivery, and sustainability?

I. Management and Oversight

LINKAGES/Laos has a very capable local management team that is supported by the LINKAGES team in Bangkok. The integrated team has the requisite range of knowledge, skills, and experience required to oversee the development and implementation of an innovative KP project. In Laos, the skill set includes the ability to work in the context of a fledgling civil-society sector, which requires close collaboration with government and civil society actors. In addition, LINKAGES has forged positive and productive relationships with its various partners, including individuals and organizations in government and civil society.

Strengths

- The work of LINKAGES/Laos is closely aligned with the priorities of the Lao national HIV response. One of the fundamental goals in the National Strategic and Action Plan (NSAP) on HIV/AIDS/STI Control and Prevention (2016-2020), approved by the Government of Lao PDR, is to ensure the HIV prevalence rate among KPs is less than 3%. The NSAP also prioritizes prevention activities among KPs, including MSM and TG populations, that are the focus of LINKAGES/Laos activities. In addition, LINKAGES’ work on improving case detection, ART uptake, and viral suppression among these populations is aligned with the government’s overall commitment to achieving the 90-90-90 targets.
- The ability of LINKAGES to expand and improve HIV-related services for KPs, including exploring innovative approaches such as OraQuick testing, is also contributing to the development of a practical management and implementation strategy for reaching KPs in Laos.
- Government stakeholders at national, provincial, and district levels recognize and appreciate the contributions of LINKAGES, particularly its ability to work with MSM and TG populations. At

the national level, there is a recognition of USAID and FHI 360's past experience in Laos – ranging from work on the HIV surveillance system to the operation of drop-in centers (DICs) for female sex workers – and its relevance to the LINKAGES project. FHI 360's broader expertise in Southeast Asia is seen as a further benefit. LINKAGES/Laos has a strong relationship with the CHAS in the MOH: senior officials at CHAS see LINKAGES as an innovative project that is providing much-needed expertise in improving the HIV response among two critical populations. The ability of LINKAGES to identify hidden populations within the MSM and TG communities and deliver HIV services to them was specifically cited as a key innovation. In general, there is an appreciation within the government of LINKAGES' commitment and ability to assemble a pool of local experts to work on the project. There is also an acknowledgement that LINKAGES has a more inclusive and professional approach to management and implementation than other projects, including joint planning processes, M&E/data systems, and administrative/financial systems.

- Although the civil-society sector in Laos is small and nascent, LINKAGES has forged a productive relationship with the Lao Positive Health Association (LaoPHA), which is the most prominent and most capable CSO working on HIV issues in the country. LINKAGES and LaoPHA work closely together at national and provincial levels to ensure activities are well managed and implemented.
- LINKAGES/Laos and LaoPHA maintain positive relationships with the health facilities involved in the project. These relationships are very important given the primary role these facilities play in implementing LINKAGES activities; i.e., LINKAGES works directly with facilities to deliver essential HIV services, including HIV testing and counseling and ART initiation and retention. The LINKAGES and LaoPHA relationships with health facilities are a reflection of equally positive relationships with the Provincial Committee for the Control of AIDS in the provinces where the project works.

Challenges

- Although LINKAGES/Laos is either close to meeting or is exceeding its main performance measures, working with KPs to improve HIV-related prevention, testing, treatment, and retention generally requires more expansive, intensive, and sustained efforts by implementing partners than comparable work with the general population. However, the metrics used to track LINKAGES' performance do not account for the additional level of effort required to motivate actions or change behaviors among individuals in KP communities. As a result, it is an ongoing management challenge to ensure implementing partners find a workable balance of outcomes, resources, and level of effort.
- Currently, LINKAGES works on a limited scale in Laos at a small number of implementation sites in Vientiane Capital and Savannakhet and Champasak provinces. However, if the LINKAGES approach is to meaningfully contribute to HIV control among KPs in Laos, other actors – ranging from international donors to national, provincial, and local governments to CSOs – need to recognize its value and support its implementation in communities where services are needed.
- A related challenge is the limited capacity within government and civil society, which could hinder their ability to act even if they are motivated to do so. This challenge is particularly acute in the civil society sector, given the limited scale, scope, and capacity of existing CSOs and the

challenges in forming and building new organizations capable of managing and implementing HIV-related activities for KPs.

2. Delivery of HIV-related Services

LINKAGES and its government and civil society partners have made a significant contribution to the provision of essential HIV services to KPs in Laos and the introduction of innovative approaches (e.g., OraQuick HIV testing) that improve the delivery and efficacy of these services. However, greater efforts are required to improve provision of services for the transgender (TG) community, which is less well served than MSM.

Strengths

- The strong relationships between LINKAGES, LaoPHA, and associated health facilities is the basis of a solid referral network in the participating districts. This coordinated network of partners provides members of KP communities with vital support (e.g., peer navigation) and essential HIV services (e.g., HIV testing and ART).
- The Enhanced Peer Mobilizer (EPM) approach is proving to be an efficient and cost-effective way to identify new HIV cases. As mentioned above, senior government officials acknowledge the ability of LINKAGES to identify and reach hidden populations in the MSM and TG communities, and they specifically acknowledge the role of the EPM approach in this, contrasting it with traditional outreach efforts that were less effective. LINKAGES is making additional adjustments to the EPM approach to further improve its effectiveness.
- The introduction of OraQuick testing for HIV is also seen as a significant innovation of the LINKAGES project in Laos. The use of OraQuick test kits is credited with improving HIV testing uptake among KPs because oral fluid testing is quicker, easier, and less intrusive than blood-based testing. However, the success of OraQuick has yet to translate into changes in government policy, due in part to concerns about the cost of the test kits.
- The combination of EPM and OraQuick into a “Test-for-Triage” model is seen as an effective way to improve testing yield. Despite some fluctuations in performance, the long-term outlook of this integrated approach is promising, given the targeted reach of EPM and the lower barriers for testing with OraQuick. The addition of peer navigators (PNs) into the equation – and their direct support to clients – extends the effectiveness of the “Test-for-Triage” model to include ART uptake by clients who are newly diagnosed with HIV. In general, partners recognize the value of this integrated approach, but they also feel there are refinements to be made that would make it even more effective (e.g., decrease the number of steps from a positive diagnosis to the initiation of ART; expand the number of sites, including civil society facilities, where ART is available).
- Formal and informal sharing of knowledge and experience has contributed to improvements in the national response as well as important adjustments in LINKAGES’ strategy and implementation plans. For example, LINKAGES/Laos participated in the development of the country’s latest Global Fund concept note, including a specific request from CHAS to share information on the EPM approach. It would be useful for LINKAGES to identify cost-effective ways to encourage a sustained dialogue on relevant knowledge and experience that could be used to improve project performance. Observations and lessons from knowledge-sharing

discussions should be incorporated into the quality improvement (QI)/quality assessment (QA) agenda moving forward.

- Government approval in late 2017 of LINKAGES new on-to-offline (O2O) strategy is a promising development, which has shown good results (e.g., a 14.5% positivity rate among clients identified using this strategy in FY 2018 Quarter 1). Combined with other micro-approaches, such as improved use of social media and index testing, it may be possible for LINKAGES/Laos to further refine its use of EPM and improve case detection.

Challenges

- The accuracy of the population size estimates for the MSM and TG communities is unclear, particularly at the local level. Having reasonably accurate estimates is critically important for LINKAGES, given the fundamental role they play in setting performance targets; without accurate estimates it is difficult for LINKAGES and its implementing partners to plan, allocate resources or track performance.
- The lack of local – and hyper-local – population size estimates makes it difficult to do the micro-planning that is a core activity in the LINKAGES approach globally. On a parallel note, the commitment to micro-planning appears weak in Laos. This may be because the project is small, but the lack of micro-planning and questions about the accuracy of the population size estimates represent a significant missed opportunity to refine the LINKAGES approach in Laos and demonstrate its effectiveness as a model for other provinces/sites.
- In the context of the concentrated epidemic in Laos, case finding is fundamental, and shortfalls in identifying new cases in recent quarters are a concern. It is clear that LINKAGES and its partners are also concerned and are working to understand and address the situation. There appear to be a variety of factors in play, ranging from clients not wanting to be tested in the field; clients preferring to be tested by a medical professional, not an outreach worker; and convoluted “rules” on who can be tested based on where they live.

Historically, the performance of EPM/Test-for-Triage versus walk-ins at a testing center (i.e., significantly better yield with walk-ins) raises questions about how EPM is being implemented and whether it is having an effect on the yield at walk-ins. For example, is EPM pushing clients to facilities for testing as opposed to Test-for-Triage? Or do clients prefer facility-based testing for other/different reasons (e.g., tests conducted by medical staff)? However, in FY 2018 Quarter 1, the Test-for-Triage approach reached an all-time high with a 5.8% yield, which may indicate modifications to the approach are making a difference.

- The use of KP_PREV as the primary measure of prevention activities shifts the focus to a “pre-test” activity; i.e., the main requirement in the indicator definition for KP_PREV is “Offer or refer the individual for HIV testing unless the person is known HIV positive.” In recent years, “treatment as prevention” has dominated the HIV prevention debate but compelling evidence exists on the efficacy and cost-effectiveness of “prevention as prevention” activities with KPs, including risk-reduction education, screening and treatment for STIs, and referral for clinical services.

Although LINKAGES does core prevention work in the MSM and TG communities, the level of effort expended on these activities is not reflected in its reporting. In addition, limited analysis is done of this work and how it can be improved.

- LINKAGES/Laos has invested in QI and QA activities, including, for example, a series of QI/QA activities in FY 2017 focused on EPM and Test-for-Triage. While work in QI/QA is continuing in FY 2018, it will be important for these activities to be institutionalized across the LINKAGES network to ensure that quality issues are an integral part of the overall approach, including project planning.
- The small footprint of LINKAGES in Laos severely limits its impact, both in terms of number of people reached and proof of concept at scale. There is widespread agreement that implementation in only three provinces – and in a small number of sites in those provinces – combined with services only for MSM and TG populations is insufficient. The limited scale of LINKAGES activities is exacerbated by limitations in the national response, including the existence of only 11 ART clinics nationwide and the small number of health facilities capable of supporting effective prevention and testing services. However, despite this, stakeholders in Laos place a high value on the LINKAGES approach.

If one of the objectives of USAID's investment is to demonstrate the effectiveness of the LINKAGES approach, it would be useful to show how it can be scaled up, even in a context with challenges that include weak CSO infrastructure, over-stretched health facilities, and stigma and discrimination linked to both HIV and KPs.

- LINKAGES/Laos has very little involvement with sexually transmitted infection (STI) diagnosis and treatment. STI services appear to be part of the larger referral network, which sends clients/patients to other facilities for different HIV-related services. However, the availability of STI services is very limited, even more so for the marginalized populations reached by LINKAGES.

3. Community and Civil Society Engagement

The small number of local civil society organizations operating in Laos limits the ability of LINKAGES to deliver services to the MSM and TG communities. Capacity issues within the sector are exacerbated by the challenges of working with these communities, including the widespread stigma and discrimination they face and their hidden nature.

Strengths

- Partnering with LaoPHA has proven to be one of the more important decisions made by LINKAGES/Laos. Community/CSO engagement is fundamental to the success of LINKAGES and, given the limited civil society infrastructure in Laos, LINKAGES needed to work with an organization that could rise to the challenge. While there have been ups and downs in LaoPHA's performance, the organization has played an invaluable role in the implementation of LINKAGES activities. In addition, LINKAGES has strengthened its capacity as an organization, making an important contribution to the development of the sector in the country and the potential sustainability of LINKAGES work.
- At the grassroots level, LINKAGES' partners appear to have generally positive relationships with the MSM and TG communities reached by project activities. However, concerns about stigma and discrimination continue to adversely affect the uptake of HIV-related services, even when they are promoted and provided by welcoming, KP-friendly individuals and facilities.

Challenges

- Limited capacity within civil society and a lack of engagement by the private sector, including private-sector health care providers, are serious constraints to the HIV response for KPs and the general population in Laos. As mentioned above, the limited capacity of civil society organizations in Laos makes it difficult to scale up the HIV response for KPs in the country. Without greater attention to the viability of the civil society infrastructure in Laos, it will be difficult or impossible to expand and sustain HIV-related activities. Moving forward, it will be especially important to have more organizations led by the MSM and TG communities.
- LaoPHA and LINKAGES are highly dependent on each other. While the relationship appears to be open and sound, the level of dependency is not sustainable. LaoPHA needs to further diversify its funding, and LINKAGES – as well as Laos as a country – would benefit from having more CSOs with the capacity to work on the HIV response. CSOs' sustainability is likely to be contingent on international funding for the next few years, as there is a consensus that these organizations will not receive direct funding from the Government of Lao in the foreseeable future.
- The lack of engagement in the HIV response by the private sector is problematic, but largely understandable given the small private-sector infrastructure in health in Laos. However, global experience has shown the private sector can play an important role in the response, including with KPs (e.g., segments of KP communities who prefer private-sector service providers because of the greater anonymity).

4. Strategic Information

There is widespread commitment within LINKAGES/Laos to the collection, analysis, and use of data that is relevant to its core activities, particularly those activities that are covered by the project's indicator set. This commitment is backed by an array of activities, ranging from M&E workshops to data quality assessments to data quality improvement exercises to data visualization. There is a clear recognition that accurate strategic information is essential to improving performance in the LINKAGES network.

Strengths

- LINKAGES has worked hard to develop a culture of data collection and use across its network in Laos. For example, the LINKAGES core team in Vientiane, as well as LaoPHA, are very conversant about the data they collect and report. Government partners, including senior staff at CHAS, also pay close attention to the data generated by the project, using it as a proxy for what can and should be done to track HIV-related activities for KPs.
- Despite a slow rollout in Laos, the eCascade management information system will give facilities access to “real time” data, which enables implementers to easily review and analyze service delivery information related to the EPM approach. eCascade is also useful in identifying “leaks” in the expanded cascade used by LINKAGES that are negatively affecting program performance. The ability to identify and address “leaks” should be even more robust when the data from HIVCAM national database on HIV and eCascade is merged. In general, implementing partners seem to be increasingly confident about using data collected on LINKAGES activities, although the analysis tends to be fairly rudimentary.

- LINKAGES is helping Laos develop “one channel” of data that will improve data collection and data use from facilities to national level. Merging data streams from HIVCAM, eCascade, and other data sources will give Laos an invaluable window on the status of the HIV work in the country. A commitment to upload HIVCAM data into the national District Health Information System (DHIS) 2 platform will further strengthen data systems in Laos.
- Steps are being taken to strengthen data quality across LINKAGES/Laos with an expanded approach to data quality assessment (DQA) and data quality improvement (DQI). This approach is built around trainings to build skills and site visits to provide technical support and independent verification of partner’s DQA and DQI activities.

Challenges

- Despite the implementing partners being conversant with their data, much of their analysis tends to be fairly rudimentary – in many cases, as rudimentary as simply acknowledging where they stand relative to their targets. The basic nature of the analysis and interpretation seems in part to be due to the absence of supporting data – typically qualitative – that would help them understand why certain outcomes are or are not happening.
- In general, a lack of data, or any substantive analysis of “why,” is a recurrent shortcoming in the approach to strategic information. Specifically, it is a lack of contextual data or analysis at the field/outreach level. For example, knowing why members of the MSM community are not willing to take an HIV test is vital information for increasing testing uptake. In addition, the lack of good information on “why” makes it more difficult to understand “how” to make adjustments to improve performance/outcomes. Similarly, while an analysis of “leaks” in the cascade is being done in limited ways, it is not as connected to the day-to-day, intensely practical work done in the field where insights from the data would be most useful.
- There are mixed feelings about the value of CommCare as a tool for data collection and use. There are concerns about the use of the CommCare platform because it is seen as additional work (e.g., the same data must be entered in physical records and on CommCare). Conversely, there are positive views about its utility for quickly and easily capturing data on clients from the MSM and TG communities and making that data readily available for use.

Evaluation Question 3: What are the constraints to successful implementation of the program?

- Stigma and discrimination towards KPs, as well as people living with HIV, is a significant problem in Laos. It negatively affects access to and uptake of HIV services that are essential to epidemic control. While LINKAGES can work to reduce the impact of stigma and discrimination in its limited spheres of influence, deep-seated fears and prejudices that underpin this stigma and discrimination require far broader and more sustained structural interventions than the project can tackle.
- OraQuick test kits, and the “Test-for-Triage” approach built around oral fluid testing, were approved by government for use in the LINKAGES project. However, these innovations have not been incorporated into national policy or guidelines. While this does not directly affect LINKAGES implementation, the inclusion of these innovations in national policy and implementation would be a signature legacy of LINKAGES.

- As mentioned above, the limited capacity of civil society to participate meaningfully in the HIV response is a serious constraint, as is the lack of domestic funds to support CSO involvement in the response. In the same vein, limited knowledge and skills relevant to working with KPs can have a negative effect on the quality of services delivered by the implementing partners.
- The small number of ART and STI clinics and lack of decentralized services at district level in Laos restricts access to these services by members of the MSM and TG communities. Although people in Laos are willing to travel extended distances for health services, concerns about the costs associated with travel and about stigma and discrimination at these sites are major disincentives to seeking care.

Evaluation Question 4: How well does the project align with PEPFAR and OHA global priorities and approaches?

The work of LINKAGES/Laos is strongly aligned with PEPFAR and OHA global priorities and approaches, especially partnerships and work with KPs. The core PEPFAR and OHA commitment to partnerships is a fundamental component of the LINKAGES work in Laos. The project has productive partnerships with government at national, provincial, and district levels and with CSOs. The ability to partner with CSOs is limited by the fledgling nature of the sector and the small number of functioning organizations. In addition, the project is aligned with the priorities of the national HIV response in Laos, including the NSAP on HIV/AIDS/STI Control and Prevention (2016-2020), which identifies work with key populations as one of its priorities.

The project's use of an expanded cascade to plan, implement, and measure its activities is also a clear reflection of its alignment with PEPFAR and OHA's commitment to epidemic control. LINKAGES acknowledges the importance of the 90-90-90/95-95-95 approach and objectives and their influence on its work.

In addition, the LINKAGES global and Laos-specific focus on work with KPs is closely aligned with the priorities of PEPFAR and OHA. PEPFAR is very clear about its support for work with these populations, stating on its website: "PEPFAR stands firmly and unequivocally with key populations. These groups include gay men and other men who have sex with men, people who inject drugs, sex workers, transgender persons, and prisoners." The website is equally clear about one of the primary reasons for working with these populations: "In almost every country in the world, members of these populations are at greater risk for HIV than the rest of the population. Globally, these key populations account for 45 percent of new HIV infections, according to UNAIDS, although they make up a much smaller proportion of the total population."

III. Recommendations

The LINKAGES network in Laos is doing vital work with populations that must be reached with essential HIV services. The topline recommendation is to continue to invest in this work while also considering a set of "course corrections" to help improve performance and impact.

- **Reinforce the consistent and recurrent use of micro-planning by the partners in the LINKAGES network.** Micro-planning is a proven approach that can play a significant role in improving the effectiveness of the community-based activities at the heart of LINKAGES. One critical outcome is better data on population size and dynamics at the local/hyper-local level, which is invaluable in identifying and implementing targeted activities linked to key objectives.

Micro-planning could also be a useful tool for piloting and assessing the value of prevention-as-prevention activities.

At its best, micro-planning is a day-to-day operational tool, not an occasional exercise.

Combining micro-planning with basic QI approaches could contribute to improved performance in areas where LINKAGES is lagging (e.g., case detection in the TG community; retention in care and viral suppression).

- **Intensify efforts to reach high-risk and hidden populations.** The above-mentioned micro-planning should be attuned to the importance of reaching the high-risk and/or hidden populations where there is likely to be a greater number of undiagnosed HIV cases and a greater need for outreach support to contribute to sustained behavior change. In Laos, LINKAGES has demonstrated its ability to reach these sub-populations. For example, EPM has proven effective, but it should be scaled up as well as continually fine-tuned to explore ways to improve and sustain its effectiveness, including the recruitment of well-connected and/or HIV-positive seeds. In addition, efforts to introduce and expand index case testing/finding at health facilities should be accelerated and closely monitored for its efficacy.
- **Continue to move toward case management as a way to improve performance across the cascade.** LINKAGES peer navigators are increasingly acting as *de facto* case managers, who work closely with their clients to ensure they remain engaged in treatment and care. In countries around the world, case managers play a vital role in implementing differentiated care; for example, navigators in Laos allocate more of their time to clients who require more attention to adhere to their respective regimens than to stable patients who need less attention. LINKAGES should consider how to better capture and convey the critical role that peer navigators play in ART uptake and retention to its key stakeholders, ranging from clients themselves to USAID and PEPFAR.
- **Continue to strengthen data harmonization across different systems.** The ongoing work to merge HIVCAM and eCascade data streams has the potential to provide implementing partners – and the MOH/CHAS – with critical insights into the effectiveness of the response as well as gaps/shortcomings that are adversely affecting performance. However, the limited deployment of eCascade and the lack of a formal plan to expand its use to non-LINKAGES sites weakens the case for investing in consolidated data streams. As a result, LINKAGES/Laos should consult with government about its commitment to eCascade as well as its capacity to support data harmonization over the long-term in order to develop a practical plan.

Help “champions” in government build the case for approval of widespread use of OraQuick tests. Key stakeholders, including “champions” in government, recognize that OraQuick should be approved for use more broadly in the country. However, there are specific concerns about the cost of the test kits. LINKAGES/Laos should work with the champions in the MOH to build a solid case for OraQuick, including a cost-benefit analysis comparing the cost of OraQuick tests with the full costs of other types of HIV tests. Currently, the basic cost comparisons done in the country only consider the cost of the test itself, not the ancillary costs (e.g., laboratory costs for blood-based tests). A solid business case could also be used to demonstrate the value of OraQuick to external funding partners.

On a parallel note, LINKAGES should also support government interest in other state-of-the-art approaches that could be effective tools in the national HIV response for KPs and the general population. Pre-exposure prophylaxis (PrEP) and self-testing are two approaches in which

government has shown interest, and there is a body of international evidence to help make the case for their use in Laos.

- **Work with government to allow and encourage private-sector provision of testing and treatment.** Although the private sector in health care is currently small in Laos, it could make important contributions to the HIV response over time, particularly given the high likelihood the number and reach of private-sector providers will increase in the coming years. Private-sector providers could be an effective way to increase the number of facilities providing quality HIV services, including testing and ART services. Any steps to increase the number of locations where ART could be dispensed and where viral loads could be tested would be an important expansion of the response in Laos and is likely to have an immediately positive impact on ART uptake and retention.
- **Provide evidence for long-term resource mobilization and sustainability.** One of the most important issues facing the HIV response in Laos is resource mobilization and sustainability, particularly the aspects of the response focused on key populations. LINKAGES could help stakeholders in Laos address this issue by providing evidence – including proof of concept of key activities and integrated approaches to working with KPs – that could be used to make the case to key funders that the work is and should continue to be a fundamental component of the national response. Additional resources are also required if the LINKAGES approach is going to be taken to scale in the country.

MALAWI COUNTRY REPORT

Introduction

LINKAGES/Malawi is the first HIV project focused on key populations (KPs) to be supported at any significant scale in the country. It is a valuable model and is being viewed as the “gold standard” by the government, multilaterals, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria for achieving 90-90-90 targets among these populations. In addition, the project contributes directly to Malawi’s National HIV and AIDS Strategic Plan 2015-2020 targets. The project is demonstrating the importance of integrating and emphasizing key structural interventions to address violence, stigma, and discrimination, which, if left unaddressed, will prevent Malawi from achieving national HIV epidemic response goals. As such, LINKAGES/Malawi is successfully demonstrating the value of an integrated approach to HIV prevention, treatment and, care.

LINKAGES/Malawi works with three local implementing partners: Youth Net and Counselling (YONECO), The Centre for the Development of People (CEDEP), and Pakachere Health and Development Institute. (A fourth partner, Family Planning Association of Malawi (FPAM), withdrew in October 2017 because it could not act in accordance with current US government policy.) The project focuses on four target groups: female sex workers (FSW), clients of FSW, men who have sex with men (MSM), and transgender (TG) populations. In FY 2018 there has also been an increased focus on families of FSW and younger adolescent girls found in hotspots. The Ministry of Health (MOH) and the National AIDS Commission provide overall leadership and policy guidance. LINKAGES/Malawi is also partnering with the Malawi Police; the Centre for Human Rights, Education, Advice, and Assistance (CHREAA); and other legal and advocacy organizations to provide an enabling environment for KPs to access HIV prevention, treatment, and care services. Finally, the project is partnering with district health offices, central hospitals, health centers, Lighthouse, Baylor Children’s Foundation, and KPs themselves to implement the project.

Operating in only six of 28 districts in the country, the “footprint” of the project is small, which limits its impact and its ability to reach a tipping point in epidemic control among these populations. The challenges presented in this report are generally known to the LINKAGES/Malawi team.

Findings by Evaluation Question

Evaluation Question 1: How effectively is the project achieving its goals and objectives?

The objectives of the LINKAGES project are to accelerate the ability of government, KP organizations, and private sector providers to collaboratively plan, deliver, and optimize services that reduce HIV transmission among KPs and their sexual partners and to extend life for those who are HIV-positive. Tables 1 and 2 show mixed performance against the indicators in FY 2016 and FY 2017. The project has effectively reached targeted populations with prevention activities in the six districts where it is operational. For example, the project exceeded the PEPFAR targets for FSW reached (KP_PREV) in the first two years of implementation, at 110% in FY 2016 and 117% in FY 2017. The parallel target for clients of FSW (PP_PREV) was also reached in FY 2017, the first year of activities for clients. Among FSW, LINKAGES had a high rate of case detection with a 41% yield in FY 2016 and 33% in FY 2017, although it is important to note that compared to the prevalence rate reported by the most recent Integrated Biological and Behavioral Survey (IBBS) it is still too low. There was also significant improvement in antiretroviral therapy (ART) uptake among FSW between FY 2016 and FY 2017.

Performance against core targets is lower in the MSM and TG populations. The project struggled to meet the MSM targets for KP_PREV, reaching only 35% of the target in FY 2016 and 52% in FY 2017, despite a reported reduction in the targets. The case detection rate was lower in the MSM and TG populations than in FSW, but 8% (FY 2016) and 6% (FY 2017) yields are very solid. Possible reasons include overestimated targets, inaccurate MSM size estimations, and programmatic challenges in reaching older and hidden individuals in the MSM community.

Table 1. Indicator Performance, including percent change between FY 2016 and FY 2017, testing yield and treatment uptake

Core Indicators	FSW			MSM/TG		
	FY16	FY17	% change	FY16	FY17	% change
KP_PREV: Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	9,601	9,930	+3%	2,086	2,071	-1%
HTS_TST: Number of KP who received HIV Testing and Counseling (HTS) services for HIV and received their test results	3,565	4,698	+32%	1300	1,677	+29%
HTS_TST_POS: Number of KP tested HIV positive (testing yield)	1,445 (41%)	1,549 (33%)	+7%	106 (8%)	99 (6%)	-7%
TX_NEW: Number of KP newly initiated on antiretroviral therapy (uptake)	610 (42%)	1,582 (102%)	+159%	61 (58%)	90 (91%)	+48%

Table 2. Indicator Performance against fiscal year targets

Core Indicators	FSW		MSM/TG	
	FY16	FY17	FY16	FY17
KP_PREV	110%	117%	35%	48%
HTS_TST	45%	59%	24%	44%
TX_NEW	16%	51%	9%	18%

The project increased coverage in sexually transmitted infection (STI) screening and treatment for diagnosed individuals. The number of individuals screened exceeds those reached as individuals exposed to the risk of STI acquisition more frequently are screened more frequently. Both the proportion of MSM diagnosed with an STI and the treatment rate among MSM were lower than among FSWs and their clients. LINKAGES reports this is because the implementing partner for MSM has to refer clients for STI treatment and only those with a confirmed referral are recorded. Although there were shortages of STI drugs earlier on in the project, systems have been put in place to ensure adequate supplies for LINKAGES programming.

In Malawi, the reported number of gender-based violence (GBV) cases is increasing. Rather than representing an actual increase in cases, this is most likely due to project efforts to ensure that peer educators (PEs), peer navigators (PNs), and beneficiaries can identify and report GBV and seek GBV-related care. Additional capacity building on violence prevention and response planned for the police, health workers, PNs, PEs, and beneficiaries is expected to further increase GBV case reporting. The proportion of reported GBV cases among MSM is lower than among FSW, as is the proportion of MSM that received post-GBV care. Based on reports from stakeholders during the evaluation visit, this may be because the environment is still not favorable for MSM to freely seek care.

The project is still in the process of scaling-up viral load (VL) services and, consequently, LINKAGES reports that few individuals have received a viral load test to date. Until FY 2018, the cascade did not yet include the number of KPs retained on ART or VL suppression rates. LINKAGES has now started reporting on these and this will support better assessment of the effectiveness of treatment and of interventions to support adherence and retention as well as tracking of losses to follow-up. (LINKAGES/Malawi reports that it has not yet identified any losses to follow up among KP on ART.)

Evaluation Question 2: What are the project's strengths, weaknesses, and/or gaps in planning, management, service delivery, and sustainability?

I. Management and Oversight

LINKAGES/Malawi maintains a core technical and administrative management team in Lilongwe based at the FHI 360 office, with other staff based within districts where the project is active. As part of the country assessment, the evaluation team met with the Lilongwe-based team as well as staff and partners in Blantyre, Mangochi, Machinga, and Monkey Bay. The Malawi team receives technical support and input from LINKAGES headquarters in Washington, DC, primarily in the areas of standardized curricula, guidelines, and Standard Operating Procedures (SOP) on a range of topics, strategic information and monitoring and evaluation, and documentation and dissemination.

Strengths

- The Malawi team benefits from excellent project leadership and is highly experienced, with strong technical, clinical, managerial, financial, and administrative staff. Ownership and accountability among staff and project partners is clear. Leadership and technical staff have good relationships with the national- and district-level MOH and National AIDS Commission (NAC) teams; community-based implementing partners; and other partners, such as the Global Fund.
- LINKAGES/Malawi is quickly becoming a national model for reaching and meeting the needs of KPs. The project is closely aligned with MOH Department of HIV/AIDS (DHA) and NAC priorities. In less than two years, its management and technical expertise has become recognized nationally, as has the LINKAGES model itself, as evidenced by requests for technical assistance (TA) from NAC, Joint United Nations Programme on HIV/AIDS (UNAIDS), and the Global Fund's Principal Recipient, ActionAid. Despite limited resources, LINKAGES/Malawi is significantly contributing to national technical capacity. Examples of TA provided include its support in addressing KP needs within the Global Fund proposal, providing critical input on an acceleration plan for Global Fund-supported implementation, and providing TA to the development of key national policy documents guiding Malawi's HIV response.
- The project is making a significant contribution towards institutionalization and sustainability of best practices in KP programming in Malawi. For example, LINKAGES/Malawi was instrumental

in establishing a National Key Populations Technical Working Group and in advocating for the designation of a KP Focal Person within NAC. The team also has supported the development of clinical guidelines and health sector strategic plans. In addition, The KP Peer Education and Navigation Training Manuals for FSWs and MSM are significant contributions towards continued programming. LINKAGES/Malawi also provides ongoing support to translate the national policy package into practice, with clear standards and guidance, including 20 SOPs addressing quality improvement and standardization. Although it took some time initially, the project now benefits from strong support by district health officers (DHOs) and systems, as evidenced by its current partnering with DHOs to support linkages between the drop-in centers (DICs), public health facilities, and outreach services.

- LINKAGES/Malawi's involvement in pilot projects is helping to ensure that the country is benefiting from service delivery innovations and new technologies. For example, LINKAGES/Malawi will help support the introduction and evaluation of pre-exposure prophylaxis (PrEP), as well as other potential testing innovations, which will inform future national strategic plans.
- LINKAGES/Malawi is maximizing the use of very lean funding. With an FY 2017 budget of about \$2.3 million and an approved FY 2018 budget of about \$3.7 million, KP_PREV targets for FY 2018 will nearly double, and additional target populations, including adolescent girls and young women will be added. Available funds must also support three implementing partners, 17 DICs, TA to the government, and robust coordination with a broad range of stakeholders, facilities, and other organizations in six districts. This means that the management team, as well as district-based staff and partners, are operating with very lean allocations. Nevertheless, the project's goals are well understood and appreciated, and there seems to be a collective commitment to maximize limited resources.

Challenges

In terms of management, there are few specific areas needing improvement. The most significant challenge – insufficient resourcing of the overall project – is covered in more detail in the Constraints section.

- Although the LINKAGES/Malawi model holds great promise for reaching hard-to-access populations and strengthening the national HIV response, current resourcing, even with an increased budget in FY 2018, is insufficient to move to significant scale-up and thus to increase impact. The LINKAGES/Malawi team continues to try and expand coverage where possible, as evidenced by its efforts to reach FSW partners and AGYW, and it has benefitted from budget support through PEPFAR's Determined, Resilient, Educated, AIDS free, Mentored and Safe (DREAMS) initiative.
- The Priorities for Local AIDS Control Efforts (PLACE) Study, commissioned to support size estimation and mapping on which the targets and design would be based, took considerable time and, as a result, LINKAGES/Malawi had to start planning and implementation before the PLACE results were available. The PLACE results were subsequently validated using a simple but very effective approach called the "Site Walk." In practice, it appears that the Site Walk was more useful and accurate than the PLACE study in estimating KP populations and mapping hotspots.
- Reaching the PEPFAR targets requires a wide range of activities and repeated contacts that are not captured or reflected in the targets. Working with KPs to improve HIV-related prevention,

testing, treatment, and retention generally requires more expansive, intensive, and sustained efforts than comparable work with other populations, due to prevailing stigma, discrimination, and social exclusion. While these challenges are not a specific weakness of LINKAGES/Malawi, the pressure to reach PEPFAR targets with limited resources and limited recognition of the range of interventions required to achieve those targets can result in a narrow focus on targets rather than on implementing the full range of activities necessary to effectively meet them. In addition, pressure on other PEPFAR partners to reach targets is sometimes creating competition for beneficiaries with, for example, other partners seeking clients for HIV testing at hotspots covered by LINKAGES implementing partners.

- The success of the LINKAGES model rests on the use of PEs, PNs, and outreach workers to reach, test, link to, and retain KP clients in treatment. These cadres are very well-prepared, knowledgeable, and confident, and it is clear that their roles are essential to the model's success. However, it is widely felt that current incentives and allowances are insufficient for covering the basic costs of their work (traveling to hotspots, accompanying peers to care, etc.) and consequently are leading some PEs and PNs to drop out. This is exacerbated by the presence of other US government partners in the same regions who are providing twice the amount of incentives to PEs, with a much lower required ratio (1:15 instead of 1:40).

2. Delivery of HIV-related Services

LINKAGES/Malawi developed a minimum comprehensive package of services for KPs that includes HIV prevention, testing, treatment, retention, and VL testing. Other key services, such as STI screening and treatment, also serve as important entry points to HIV testing. The comprehensive KP service package is delivered through a combination of four models:

- **Drop-in Centers:** DICs are dedicated safe places for KPs where services are provided by project staff and, in some cases, DHO health care workers providing outreach for ART services.
- **Clinical Outreach:** Outreach services are provided on site at hotspots or KP community locations by PEs, PNs, outreach workers, and DHO health care workers.
- **Static Clinics:** These are selected private clinics within the referral network with staff trained in the LINKAGES model. However, with the transition from FPAM to Pakachere, these standalone clinics will no longer be supported.
- **Hybrid Health Facilities:** The hybrid model ensures that clients from project sites (e.g., DICs) are effectively referred to public health facilities, where staff have been trained by LINKAGES.

The diversity of models to provide HIV testing services (HTS), STI screening, sexual and reproductive health services, ART, and VL testing demonstrates a context-sensitive and flexible approach to enabling KPs to access clinical care in safe spaces. This diversity increases the acceptability, accessibility, and sustainability of KP-oriented services.

Strengths

- PEs demonstrate confidence in using LINKAGES/Malawi tools and resources. These include the enrollment form and peer plan for identifying and reaching KP with prevention messages; supplies of lubricants and condoms; simple verbal assessments for STI and tuberculosis (TB) screening; GBV identification and prevention measures, and referral tools for STI, TB, HTS; and post-exposure prophylaxis (PEP). Observation at several hotspots suggested that PEs are confident and knowledgeable regarding condom and lubricant distribution. Through discussions with beneficiaries, the evaluation team noted the project's tailored prevention messages are reaching KPs who have been missed by mainstream health services. For example, KPs previously could only access condoms at shops or through health facilities during the day, whereas LINKAGES/Malawi now provides condoms, as well as lubricant (not previously available), for free through the PEs and PNs. In addition, mainstream prevention messages target heterosexual transmission of HIV and STIs only, leaving out critical information for MSM and TG populations. Based on interviews with beneficiaries and PEs, it is clear that KPs appreciate the DIC model as they are able to access more comprehensive and relevant information than is typically available to them. The DIC also provides an important safe space for recreation and group support. In some settings, PEs and beneficiaries are also using the DIC as meeting places for discussing and planning income generating activities.

"We are grateful to LINKAGES that, even at night, we can just knock at our Support Group Chair's door and easily access condoms and lubricants. We used to use Vaseline (petroleum jelly) or cooking oil but now we have lubricants." –FSW from Umodzi Support Group

"Before LINKAGES, I did not know that one can contract HIV through having sex with another man or STIs through oral sex." –MSM Peer Educator
- PNs are successfully providing a comprehensive service package for newly diagnosed HIV-positive clients and linking them to treatment. The PNs also track those previously tested HIV-positive and link them to the DIC or a referral clinic for ART. Additional PN responsibilities include providing psychosocial and ART adherence support for those on ART, providing reminders for VL testing, distributing condoms and lubricants, and making referrals to clinics. They also work with the DIC to track clients who have stopped or defaulted on treatment and link them back to care. Because each DIC is strongly linked to a public health "mother" facility, client tracking and follow-up is well integrated into programming and supported by project-developed Unique Identifier Codes (UICs) as long as the client remains in the project catchment region.

"I rank LINKAGES as the best program of all others going on here because it reaches out to people whom we had failed to reach.

It was not easy to convince the health care workers to provide services to KPs. We had to meet the health care workers and the District Medical Officer to convince the health care workers and used the human rights/medical ethics approach. Now we have good collaboration and results."

–Blantyre District Health Officer
- The District Health Officer (DHO) is responsible for providing ART drugs, HTS kits and supplies, and STI drugs. It also uses the DIC as an outreach site, which is linked to a "mother" facility. The hotspot/outreach clinics are conducted with LINKAGES/Malawi partners and the DHO, who, together, follow the MOH reporting guidelines for accountability. The DHO also provides supervision to the DIC to ensure quality standards are maintained.

Challenges

- The frequency of ART services offered at DICs, as well as DIC coverage, remain limited, although demand is high. DICs rely on referrals and use their space only as outreach facilities for dispensing ART, given that DICs are not permitted to act as standalone clinics. ART outreach services at the DICs are available only once a week; LINKAGES plans to train DIC clinicians as ART providers to increase availability of ART services. Other services, such as HTS, family planning, STI screening and treatment, TB screening, GBV screening, and referrals for opportunistic infections are provided daily by the DIC project clinician. Additional services that may be included at the DIC but missed by public health facilities (or referred onward) are mental health screening, alcohol/drug abuse screening and support, and PEP. Interviews with PEs and PNs indicated that they preferred services at the DIC as some referrals cost money. For example, in Monkey Bay, one of the referral sites is a Christian Health Association of Malawi (CHAM) facility, which only offers ART and HTS for free, while other services are fee-based. Other PEs and PNs reported that some clients refuse to visit a health facility if they must pay for transport. Others expressed concern that TG-specific services, such as hormone therapy education, were not available. A systematic assessment of what DIC clients might want to include in a “one-stop-shop” could help inform whether or how to add other services.
- Too few DICs exist to cover all catchment areas, which has meant that PEs and PNs are escorting peers to public health facilities that are far and thus expensive to reach. A DHO concern is that the DICs utilize rented facilities, which poses a sustainability challenge regarding how to maintain the gains made by the LINKAGES/Malawi project over time. Further, FSWs are mobile and hence require broader coverage for effectiveness.
- Viral load services coverage is still low and the turn-around time for VL testing is lengthy. By the end of September 2017, only 77 FSWs had had VL tests and results, against the 440 FSWs initiated on ART in FY 2016. This represents about an 18% coverage rate. While VL testing is still not generally available, national coverage was at 57% by the end of September 2017. It is critical for LINKAGES/Malawi to have reached 75% coverage by the project’s midpoint, and to have evidence to assess viral suppression, which is fundamental to reducing new infections. The current turnaround time for VL results can be up to two months, and samples get lost or are rejected due to weak tracking systems (although turnaround time is shorter in some sites, such as Monkey Bay and Mangochi, where point-of-care testing is available, and LINKAGES has a good tracking system and strong links to VL monitoring laboratories). While VL samples will soon be collected from DICs, this will not fully resolve the issue of delay due to long turnaround times from referral laboratories.
- Providing the comprehensive continuum of HIV services to KPs depends on the success of the models of service delivery. While the DICs are supervised by the DHO and the LINKAGES/Malawi team, PEs, PNs, and outreach workers expressed frustration at the lack of adequate transport for conducting outreach services and of clinical supervision to ensure quality of outreach services.
- While LINKAGES/Malawi receives STI drugs through the DHO/public health system and the LINKAGES project is prioritized, actual supply still depends on availability. The public health system, on several occasions, has experienced stockouts, leaving LINKAGES/Malawi without STI drugs.

3. Community and Civil Society Engagement

An important hallmark of the LINKAGES model is its focus on building capacity of local community-based organizations, especially those that are KP-led, so that they can significantly contribute to the epidemic response. As noted, LINKAGES/Malawi is currently working with three main local partners: Pakachere, CEDEP, and YONECO. Of these, only CEDEP is KP-led, although the other two have made efforts to hire KPs into their staff. With LINKAGES and Counterpart International support, these groups are successfully creating localized, KP-specific platforms for delivery of essential services tailored to the needs of MSM, FSWs, and sex worker clients.

Strengths

- LINKAGES/Malawi excels in engaging, empowering, and building capacity of KPs and local implementing partners. The project has built significant technical, managerial, and individual capacity through its partnership with Counterpart International, which was already on the ground as a capacity-building partner for community-based organizations engaged in HIV. With this support, each partner has moved from being primarily focused on social and behavior change communication, HTS, and advocacy, to including clinical services, managing PEPFAR funding, and engaging in effective monitoring and evaluation. Counterpart has used tools common to Pact and other TA providers, namely the Integrated Technical Organizational Capacity Assessment (ITOCA) and Organizational Performance Index (OPI) processes, to identify, address, and monitor areas requiring improvement annually. This support has added tremendous value, with clear, measurable changes (per the OPI) in capacity across all organizations receiving support. Furthermore, each of the 17 DICs has an Advisory Committee made up of PEs, PNs, and clients, which takes the lead in managing the DIC as a safe space. Strong coordination with the district health leadership has been established with KP participation.
- LINKAGES/Malawi has succeeded in building capacity of PEs and PNs on which the success of the project largely rests. Many PEs and PNs clearly felt ownership, commitment, and satisfaction from helping their communities. They reported improved knowledge, skills, and positive behavior change, thanks to the availability of webinars, support groups, mentoring, and training. All PNs and PEs demonstrated good command of materials, use of forms, use of data, and commodities. Further, the LINKAGES/Malawi team supported several PEs to prepare successful poster abstracts for the 2017 ICASA conference in Abidjan, thus putting “Nothing about us without us” in practice.

“This program has changed many people’s lives – both HIV- and HIV+. I know who I am now. I know my status and I can teach my friends.” –FSW PN at Hotspot, Lilongwe

Challenges

- There are insufficient numbers of KPs in leadership and management positions, and there is an absence of TG representation organizationally and individually. This reflects to some extent the limited number of KP-led organizations in Malawi; CEDEP is the only national MSM organization and it faces many demands. Although the two non-KP-led implementing partners have hired some KP staff, the project needs to identify and cultivate additional organizational and individual KP leadership through focused capacity-building. While it is clearly understood that the social environment in Malawi is conservative, and emergence of such leadership is difficult, there are

several TG PEs in Lilongwe and Blantyre, whose interests are currently subsumed under those of MSM communities. The project commenced targeted efforts to reach TG communities in FY 2018, but additional efforts are required to elevate and support TG leadership and TG-specific programming.

4. Structural Interventions

LINKAGES/Malawi has made considerable progress in making structural interventions that address violence, stigma, and discrimination central to project implementation.

Strengths

- LINKAGES/Malawi has invested in tools, partnerships, and capacity to strengthen and ensure sustainability of interventions addressing violence. All partners, PEs, PNs, and Outreach Workers who met with the evaluation team expressed great appreciation for the significant attention being paid to integrating systematic violence response mechanisms into core programming. For example, LINKAGES has developed a Gender-based Violence Training Manual and related SOPs to increase knowledge and understanding of the definition of GBV among implementing partners, PEs, PNs, and clients. This has resulted in sharp increases in GBV reporting, most likely due to an improved understanding of what constitutes violence (rather than an increase in actual GBV cases), and more than 80% of reporting occurs within 24 hours of the incident. In addition, all DICs have established Crisis Management Committees and have or will soon put in place GBV helplines to handle incidents of violence. As part of this effort, the project has conducted trainings for health care workers, violence support units, Crisis Management Committees, and GBV Helpline personnel, and it has mapped service providers and defined partner roles and responsibilities in addressing violence. Post-violence packages, comprising HTS, STI, PEP, psychosocial counseling, emergency, contraception, and systematic referrals also have been standardized. In addition, LINKAGES/Malawi is a member of the GBV sub-group of the National HIV Prevention TWG.
- LINKAGES/Malawi has forged promising partnerships with the police in some districts. Interviews with two police representatives in Mangochi, for example, suggested that the partnership with the project was effective, and that they understood that FSWs deserved fair treatment and access to appropriate recourse if subjected to violence. Arrests for “loitering” (often used against sex workers) have also apparently gone down. Meanwhile, Pakachere reported that they have seen a decrease in police violence against FSWs in Blantyre.
- Training and sensitization of health care workers to reduce stigma and discrimination, though still limited, has been highly appreciated. LINKAGES/Malawi has pursued a strategy of training health care workers in provision of KP-friendly services in public health facilities within the DIC catchment areas. Following training, positive changes in attitudes have also been noted among government health workers who provide outreach services within DICs. LINKAGES/Malawi is now trying to measure changes in attitudes and behaviors among health workers towards KPs through application of the “service quality monitoring system via SMS” or SMS² system. Baseline data were collected via a participatory process with KPs, and follow-up data are now being

“The police provide an enabling environment that accommodates everyone to live positively, including female sex workers... They are human beings.” –Police officer, Mangochi

collected using SurveyMonkey with service providers and clients to assess changes, with the goal of creating an ongoing feedback loop to inform continuous quality improvement.

- There is considerable demand from DIC clients, PEs, and PNs for other interventions, including skills training, economic empowerment, food supplements (especially for those on ART), family support services, and interventions targeting younger adolescent girls at hotspots. None of these activities is currently funded through the LINKAGES/Malawi scope of work, although the project has leveraged several opportunities by linking clients to services (food supplementation through the Food and Nutrition Technical Assistance Project [FANTA]) and providing encouragement and advice to HIV support groups to start and maintain village savings, and in the future, additional strategic partnerships will be necessary to address wider needs.

Challenges

- Structural interventions related to violence prevention and response, while strong, remain limited in scope and coverage. Although training with police, DICs, PEs, and PNs has been very effective in creating a violence reporting and response system, these groups are asking for more support, including training and SOPs, to reduce the reporting burden. In addition, little attention is paid to the need for legal support. CHREAA is meant to provide such support pro bono, but it does not really have the bandwidth to do so effectively. Furthermore, the project does not have a strong violence prevention element. Specifically regarding partnerships with police, coverage of training is still limited in terms of numbers of officers trained, and training content thus far has focused more on improved responsiveness to FSWs than to MSM or TG populations.
- Coverage of health care worker training on stigma and discrimination has been limited, and establishing the SMS² system has been challenging. As of October 2017, 62 health care workers had been trained in providing KP-friendly services; however, ongoing staff turnover and lack of coverage of entire units weaken the potential benefits of the training. Partner staff and beneficiaries also suggested that more work within surrounding communities be done to reduce stigma and discrimination. Further, the SMS² system has been slow to get off the ground due to technical challenges. It is still unclear how it will be used across the life of the project, although introduction is still planned.
- Despite strong evidence of the importance of sobriety to engaging in HIV risk reduction behaviors (e.g., consistent, correct condom use) and ART adherence, substance abuse is not given much sustained attention or support beyond its inclusion in the risk assessment tool.
- Some PEs, PNs, and the police are not fully aware of referral options for social protection services for underage adolescent girls and young women, although LINKAGES/Malawi has sought coordination with three partners (Baylor University, 4 Children, and One Community), to establish a referral system at the national level.

5. Strategic Information

Data management system standards for KP programming should recognize that site-level monitoring and individual tracking are needed to ensure that KP individuals routinely access high quality, efficient outreach, and clinical services. LINKAGES/Malawi complies with the MOH reporting system and data collection, and has also developed data collection tools for effective registration/enrollment, provision of services, referral systems, and individual tracking tools for peer outreach.

Strengths

- LINKAGES/Malawi has excelled in building local implementing partners capacity in M&E with established data quality standards. The project provides training, ongoing mentorship, and TA in establishing data quality standards, and the system is now functioning well, with reports of improved data quality.
- Data are being used to guide programming and improve the quality of implementation at all levels, including among PEs and PNs and at the DIC, district, project, and national levels. For example, PEs, PNs, and staff demonstrated use of the tools (opportunity gap analysis) and data in program improvement (monthly and quarterly reviews).
- LINKAGES/Malawi has designed and implemented an electronic management system (eCascade) for data collection, analysis, and reporting based on the District Health Information System (DHIS) 2 system. To ensure compliance with the MOH DHA M&E system, all services provided through health facilities, DICs, and outreach are documented in MOH registers. Data on supply estimates are also checked for accuracy. The data Dashboard was introduced and is fundamental to data use and performance improvement. In addition, the DICs have the capacity to generate UICs for new clients to enable tracking throughout the continuum of services and minimize loss to follow-up. Moreover, it is an opportunity for cohort analysis (STI, HIV incidence, survival analysis, etc.), which has potential to demonstrate project impact.

Challenges

- M&E capacity among local implementing partners still needs strengthening. For example, CEDEP has had a high turnover of M&E staff and has only one M&E Officer, which is not adequate for the project. As a result, DIC managers are spending significant time entering data. This can compromise quality, considering that there are several activities required to meet M&E data quality standards, including data verification/audit exercises. Technical staff are not always included in M&E training, which would be beneficial so that they understand indicator definitions and data use.
- There is a general lack of confidence in the MSM size estimations. MSM positivity rates and reach are lower than set targets in project sites, which raises questions about whether the targets may be based on incorrect estimates. LINKAGES may need to invest in further size estimation and mapping, as well as expand the use of the Enhanced Peer Outreach Approach (EPOA), to better characterize the MSM population and the resources required for effective reach.
- There are concerns that DHIS 2 data entry is limited to the DIC level. Further, external constraints, such as electricity blackouts, hinder use of DHIS 2 and computer-based reporting. An additional constraint is that PEs and PNs tend to be low-literate and need significant support and supervision regarding data entry.
- Some indicators that are pivotal to project and cascade monitoring have not been included in the Dashboard, but LINKAGES has started to monitor these as of FY 2018. These indicators include:
 - TX_CURR – Number of KPs currently receiving ART

- TV_PVLS – Percentage of ART patients (KPs) with viral load result documented in the medical record or Laboratory Information Management System within past 12 months with a virally suppressed viral load (<1000copies/ml)
- TX_RET – percentage of KPs with HIV known to be alive and on ART 12 months after ART initiation.

Evaluation Question 3: What are the constraints to successful implementation of the program?

- The primary constraint facing the project is that it is under-resourced for the scope, scale, and importance of the effort. Effectively engaging KPs in the national HIV epidemic response requires high-intensity, frequent intervention, especially at the start of a project. While LINKAGES/Malawi has been remarkably effective despite resource constraints, available resources prevent full realization of the intensity, scope, and coverage of critical elements, such as creation of additional DICs and safe spaces, ongoing stigma and discrimination reduction efforts within public health facilities, and expansion of other structural interventions. Finally, limited resources limit the project's ability to meet the requests of the MOH, NAC, and the Global Fund to provide technical support and capacity-building to replicate the LINKAGES model in other districts, a potentially significant missed opportunity if alternative resources are not identified.
- Although Malawi's anti-sodomy law carries a penalty of up to 14 years, prosecutions are currently suspended. However, Malawi's conservative religious environment has led to pervasive societal homophobia and transphobia, keeping many of these KPs away from needed health services (including treatment enrollment and retention). Sex workers, as well, may be targeted by police and subjected to further violation, blackmail, and abuse, with few avenues for pursuing justice. Finally, many KPs are economically marginalized, leaving them vulnerable and disempowered. For example, some FSWs are essentially indentured by bar owners, who prevent the project from providing these women with needed services.
- One of Malawi's original clinical partners, the FPAM, had to withdraw from the project as it could not act in accordance with current US government "Protecting Life in Global Health Assistance" policy. Pakachere was selected as its replacement, but the transition has resulted in some delays in implementation of program components targeting FSWs.
- As in many countries and many programs, the lack of a common UIC that spans prevention and treatment makes tracking of clients across the cascade difficult, but LINKAGES is making good progress in trying to address this challenge.

Evaluation Question 4: How well does the project align with PEPFAR and OHA and global priorities and approaches?

The work of LINKAGES/Malawi is strongly aligned with PEPFAR and USAID Office of HIV/AIDS (OHA) global priorities and approaches, especially partnerships and work with KPs. The core PEPFAR and OHA commitment to partnerships is a fundamental component of the LINKAGES work in Malawi. The project also has productive partnerships with government at national, provincial, and district levels and with civil society organizations. In addition, the project is aligned with the priorities of the national HIV response in the country, including the National HIV and AIDS Strategic Plan 2015-2020.

The project's use of an expanded cascade to plan, implement, and measure its activities is also a clear reflection of its alignment with PEPFAR and OHA's commitment to epidemic control. LINKAGES acknowledges the importance of the 90-90-90/95-95-95 approach and objectives and their influence on its work.

In addition, the LINKAGES global and Malawi-specific focus on work with KPs is closely aligned with the priorities of PEPFAR and OHA. PEPFAR is very clear about its support for work with these populations, stating on its website: "PEPFAR stands firmly and unequivocally with key populations. These groups include gay men and other men who have sex with men, people who inject drugs, sex workers, transgender persons, and prisoners." The website is equally clear about one of the primary reasons for working with these populations: "In almost every country in the world, members of these populations are at greater risk for HIV than the rest of the population. Globally, these key populations account for 45 percent of new HIV infections, according to UNAIDS, although they make up a much smaller proportion of the total population."

III. Recommendations

Overall, the evaluation team was deeply impressed with the work of LINKAGES/Malawi, and the team's topline recommendation is to continue to invest in this important project.

National Leadership, Capacity-building, and Sustainability

- **Identify additional resources to enable LINKAGES/Malawi to provide technical support and mentorship to government and other partners.** To maximize the potential impact of the LINKAGES model in Malawi, the evaluation team strongly recommends additional resources be identified to allow the project to allocate staff dedicated to TA, mentorship, and training to national partners, including Global Fund principal and sub-recipients. Related to this, the project, in partnership with the MOH, could identify potential operations research questions based on quarterly or annual reporting that would inform future planning.
- **Initiate discussions and analysis regarding expansion, sustainability, and cost-effectiveness.** This would include ongoing analysis of governmental and civil society capacity to scale-up the LINKAGES model throughout Malawi using a Quality Improvement approach and conducting mapping and cost analysis to determine potentially high-impact placement of additional DICs, when funding allows.
- **Continue identifying opportunities to amplify KP voices and build KP individual and organizational capacity.** This would include identifying other KP-led groups or nascent NGOs that could grow into effective implementing partners, supporting exchanges between and among PEs, PNs, and DICs and, as resources allow, arranging visits within Malawi and to other LINKAGES countries in region.
- **Consider analyzing who currently accesses services through the different models (DIC, Outreach, Hybrid Health facility).** Such an exercise could be used to inform the expansion and strengthening of interventions and services as well as identify gaps. In addition, surveying clients on what types of services are or would be most valued could inform the most optimal models, by population, of "one-stop shop" service delivery.
- **Review the allowance standards for PEs and PNs. A first step would be for USAID and PEPFAR in Malawi to standardize compensation of comparable cadres (PEs,**

PNs) to avoid unhelpful competition among USG partners. As part of this exercise, USAID and LINKAGES should estimate the level of effort that PEs and PNs now contribute to the project – and upon whom the success of the project rests – and consider moving towards higher compensation to avoid high turnover. Other benefits, such as creating a pool of shared bicycles for PE and PN transport, are also recommended. In addition, stronger PEPFAR leadership and closer collaboration between PEPFAR partners is required to avoid duplication of effort and competition for clients between partners.

Stigma, Discrimination, and Violence

- **Improve the safety and security of PEs and PNs.** Many MSM PEs, and PNs reported that carrying paper-based tools put them at risk of being exposed and subjected to violence. Alternative approaches are required to reduce this risk. In addition, DICs serving FSWs should develop written protocols on safety and security, similar to those developed by MSM-focused DICs.
- **Strengthen interventions on violence prevention and response.** Specifically, interventions to strengthen violence prevention could include using lessons learned from GBV violence response mechanisms as the basis for violence prevention planning. In addition, greater attention should be paid to training and sensitizing legal and judicial stakeholders in KP needs to improve post-GBV reach and response. Finally, partnerships with police should be expanded, both in terms of geographic coverage and coverage of training and sensitization of officers within existing sites.
- **To the extent possible, characterize the problem of and develop interventions for indentured FSWs.** At a minimum, developing a system for these women to report abuse and access basic HIV-related and other health services would be an important contribution to their safety and well-being.

Maximizing Coverage and Reach

- **Develop an MSM strategy.** This should address concerns about size estimates, poor performance, and monitoring and should include use of specific approaches, such as building on the success of EPOA in identifying older MSM.
- **Consider a pilot mapping exercise for people who inject drugs (PWID).** This population remains unsurveyed in Malawi but is thought to exist. If resources allow, the project is well positioned to do some preliminary research to characterize the basic scope and geographic distribution of PWID in the country.

Maintaining program quality

- **Continue to improve tracking of clients who move from prevention to care and treatment.** This could include further strengthening the UIC system by sensitizing beneficiaries to its importance, as well as expanding the system to other districts to facilitate tracking of KPs who are mobile. Tracking clients who remain HIV-negative should also be considered to highlight the value and impact of prevention activities.
- **Monitor all indicators of the cascade in the project Dashboard, with particular attention to retention and VL suppression, to refine planning and target interventions for improved results.** As the project matures, it will be important to include

all indicators across the cascade. To strengthen access to VL testing, LINKAGES could collaborate with the MOH DHA Diagnostic Department to institute active VL tracking (e.g., use of the National VL dashboard, proactive follow-up at the laboratories). In addition, strengthen routine data analysis and additional analysis, for example, age disaggregation of data.

- **Strengthen collaboration with the MOH on M&E-related issues.** Specifically, ensure compliance with the national M&E system for documentation and reporting at DIC, Outreach, and referrals; regularly review data and systems with the MOH and triangulate data to provide confidence; conduct cohort STI monitoring and survival analysis to assess if prevention interventions are working; and look at age-standardized rates for different variables (condom use, HIV prevalence, STI prevalence, retention, viral suppression) for comparisons.

LINKAGES/Malawi is appreciated among all stakeholders as a reference model for KP programming and has the potential to accelerate the country's efforts in reaching the 90-90-90 and national HIV program targets. The project is partnering with a broad range of health, advocacy, public service, and human rights partners to strengthen HIV prevention, care, and treatment services for KPs in six of Malawi's 28 districts. Current performance indicators suggest the project has been successful thus far in reaching KPs with integrated high-quality services despite limited funding. Essential to success has been the highly effective capacity-building TA provided to local partners, which were new to providing clinical services. The evaluation team strongly recommends support be continued, and notes that addressing the recommendations above should further strengthen LINKAGES' effectiveness during the remaining time of the project.

THAILAND COUNTRY REPORT

I. Introduction

The LINKAGES project in Thailand builds on a long and successful history of USAID partnership with government and civil society at national, provincial, and district levels. LINKAGES/Thailand is also continuing USAID's sustained involvement with key populations (KPs) in Thailand in order to address and mitigate the impact of HIV in these populations. Most importantly, LINKAGES is leveraging a history of innovation in Thailand that has made its HIV response so successful. However, the challenges for LINKAGES are significant because it is increasingly difficult to identify and engage the populations most affected by HIV in Thailand. Behaviors are fluid; mobility is high; and the effectiveness of different communications technologies to reach KPs varies widely. Adaptive approaches such as the Enhanced Peer Mobilizer (EPM) approach are more effective than traditional peer outreach; conversely, one-on-one support (e.g., the role of peer navigators [PNs]) is more important than ever. Epidemic control in Thailand is achievable but the proverbial "low hanging fruit" is gone. It takes more time and more effort to provide prevention, testing, and treatment services to the marginalized and stigmatized populations who are bearing the brunt of HIV at this time.

II. Findings by Evaluation Question

Evaluation Question I: How effectively is the project achieving its goals and objectives?

LINKAGES/Thailand has helped the government and civil society improve their ability to individually and collectively plan, deliver, and optimize HIV prevention and treatment programs for KPs in Thailand, including men who have sex with men (MSM), transgender (TG) populations, and female sex workers (FSW). There is also an emerging relationship with the private sector designed to integrate its capacity into what has the potential to be a strong tripartite approach to improved service delivery and better client/patient – as well as public health – outcomes.

In geographic locales where LINKAGES is active, the combination of infrastructure and services provided by government, civil society, and private sector partners dramatically improves the quality and availability of support and assistance for members of KP communities. The integrated model of service delivery (e.g., a combination of outreach activities, hybrid drop-in centers/clinics, pre-exposure prophylaxis (PrEP), links to other relevant services, and ongoing case management), which LINKAGES/Thailand has helped its partners develop and implement, is effective and it could have a far greater impact on the HIV response in Thailand if it was taken to scale with additional donor or domestic funding.

LINKAGES/Thailand has also made important contributions in other areas of the HIV response. Its collaboration with the Thai Red Cross AIDS Research Centre (TRC-ARC) on operations research and feasibility studies are forward-thinking investments that are likely to have long-term positive effects on the Thai response. For example, operational research on HIV oral fluid screening (e.g., OraQuick) is anticipated to lead to regulatory approval in Thailand of a testing modality that could improve HIV case detection among hard-to-reach individuals. Similarly, a feasibility study on point-of-care testing for a) HIV viral load and b) sexually-transmitted infections in community-based clinics could lead to improvements in a) ART adherence and retention and b) prevention and testing behaviors.

LINKAGES' performance in Thailand has been mixed. One notable positive is the high testing yield among MSM and TG clients: 10.8% in FY 2016 and 10% in FY 2017. Only Indonesia (13.6%) and Côte d'Ivoire (11.1%) had better yields among this population in FY 2017. The solid performance can be

linked to the use of the EPM approach in Thailand. The testing yield among FSW was far lower at 1.3%. However, it is important to note that LINKAGES/Thailand activities with this population were newly added in the end of 2017 due to a planned Global Fund transition, and that HIV prevalence in this population has declined over time; case finding among FSW appears to be consistent with reported HIV prevalence.

Another notable positive in Thailand is the project's performance in PrEP initiation. In FY 2017, LINKAGES was responsible for 1,782 people starting PrEP, which was 172% of their target for PEPFAR's PrEP_NEW indicator. Given that Thailand is one of only two countries in LINKAGES – Swaziland being the other – with the ability to significantly surpass the PrEP target, there is a case for expanding the use of PrEP in Thailand and other LINKAGES countries.

Where trend data is available, there was generally strong improvement in FY 2017, with triple-digit growth for HTS_TST, HTS_TST_POS and TX_NEW among the MSM/TG population. However, overall performance against the PEPFAR targets is disappointing with none of the targets reached for the core indicators in FY 2017.

There is one important caveat to consider in Thailand when reviewing LINKAGES' performance. There are data in the country suggesting the possibility of an overall decline in HIV prevalence among MSM. If this is the case, there may be a need to readjust the project's targets and implementation strategy.

Table 1. Indicator Performance, including percent change between FY 2016 and FY 2017, testing yield and treatment uptake

Core Indicators	FSW			MSM/TG		
	FY16	FY17	% change	FY16	FY17	% change
KP_PREV: Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	FSW activities started end of FY17	5,538	---	65,729	55,800	-15%
HTS_TST: Number of KP who received HIV Testing and Counseling (HTS) services for HIV and received their test results		783	---	9548	34,055	257%
HTS_TST_POS: Number of KP tested HIV positive (testing yield)		10 (1.3%)	---	1030 (10.8%)	3408 (10%)	231%
TX_NEW: Number of KP newly initiated on antiretroviral therapy (uptake)		4 (40%)	---	748 (73%)	1,916 (56%)	156%

Table 2. Indicator Performance against fiscal year targets

Core Indicators	FSW		MSM/TG	
	FY16	FY17	FY16	FY17
KP_PREV	FSW activities	88%	388%	97%
HTS_TST	started end of	17%	75%	79%
TX_NEW	FY17	5%	102%	35%

Evaluation Question 2: What are the project's strengths, weaknesses, and/or gaps in planning, management, service delivery, and sustainability?

I. Management and Oversight

LINKAGES/Thailand has a strong and seasoned management team with the wide range of knowledge, skills, and experience required to oversee the development and implementation of a complex and innovative project focusing on KPs. In addition, LINKAGES/Thailand has forged positive and productive relationships with its various partners, including individuals and organizations in government, civil society, and the private sector. Within civil society, there has been a particular effort to develop good working relationships with organizations led by people from the different KPs.

Strengths

- The project is closely aligned with the priorities of the national HIV response in the country. Thailand's National AIDS Strategy (2017-2030) prioritizes work with KPs, given the epidemiology of the country's HIV epidemic. It also acknowledges the importance of working with community groups to reach these populations. In addition, the strategy recognizes the need to tailor activities to specific populations in specific locations.
The ability of LINKAGES/Thailand to expand and improve HIV-related services for KPs, including exploring new/innovative approaches, is also directly relevant and contributory to the development and execution of a practical management and implementation strategy to reach the 90-90-90 goals in Thailand.
- Government stakeholders at national, provincial, and metropolitan levels recognize and appreciate the multiple contributions of LINKAGES to the HIV response, particularly its expertise in working with KPs. They readily acknowledge the project's ability to initiate and support essential and innovative activities in HIV prevention, testing and treatment.
- LINKAGES/Thailand has built on the long-standing relationship that USAID and its implementing partners have had with the TRC-ARC. As mentioned above, this relationship enables LINKAGES and TRC-ARC to leverage their respective expertise and experience to pursue longer-term, forward-thinking HIV interventions that will be needed to reach and maintain epidemic control in Thailand. The LINKAGES/TRC-ARC relationship also reinforces LINKAGES' credentials as one of the pivotal actors in the national response.
- Local implementing partners – including KP-led organizations – are central to the success of LINKAGES-supported activities in Thailand. While there are inevitable challenges in building and maintaining the relationships with civil society organizations (CSOs), LINKAGES has capitalized on the long and successful history of participation of Thai CSOs in USAID-funded HIV projects.

- Practical collaboration between the project's local implementing partners and government hospitals and clinics has been central to the successful management and delivery of services to key populations. Referrals to hospitals and clinics for HIV services (e.g., antiretroviral therapy [ART], viral load testing) are a fundamental component of the LINKAGES approach. However, the effectiveness of those referrals for members of KPs who are easily marginalized, stigmatized, and discriminated against, hinges on a KP-friendly environment, including proficient and non-judgmental staff. Joint efforts by implementing partners and participating health facilities to ensure services are delivered in ways that support positive and sustained engagement with KP clients have improved the quality of service delivery, despite the continuing challenges of stigma and discrimination.
- The ongoing involvement of peer navigators (PNs) from the implementing partners in helping members of KPs complete their referrals and remain in treatment plays a major role in the quality of the relationship between the CSO partner and the health facility.
- Good relationships with provincial authorities (e.g., Provincial Health Office [PHO], Department of Disease Control [DDC], and National Health Security Office [NHSO]), including the provision of training and technical assistance, contributes to an overall positive environment and has helped facilitate CSO engagement with government hospitals and clinics. However, LINKAGES/Thailand should consider what level of investment in training and technical assistance is necessary or useful to ensure productive and effective engagement with government counterparts.

Challenges

- Working with KPs to improve HIV-related prevention, testing, treatment, and retention generally requires more expansive, intensive, and sustained efforts by implementing partners than comparable work with the general population. However, existing metrics used to track LINKAGES/Thailand's performance do not account for the additional level of effort required to motivate actions or change behaviors among members of KPs.
- CSO partners in Thailand – particularly KP-led and KP-centered organizations – have long relied on donor funding (e.g., USAID and Global Fund) to support their operations. LINKAGES/Thailand has been working with these partners to develop other sustainable models of operation (e.g., fee-based services in CSO-operated clinics; reimbursement from NHSO for services delivered) but it is highly unlikely that these organizations will be able to develop a self-sustaining funding model that does not include external funds of some sort. Given shifting dynamics in the international donor community, sustainability is likely to hinge on funding from Thai government sources (e.g., Thai Fund). LINKAGES/Thailand has had some new success in helping NHSO to invest in local CSOs and reimburse them for HIV services.
- Currently, LINKAGES works at limited scale in Thailand. Modest expansion is ongoing (e.g., new sites in Ubon Ratchathani and Chiang Rai in FY 2018 Quarter I). However, if the LINKAGES approach to working with KPs is going to have a larger, sustained impact on the overall HIV response in Thailand, other organizations – ranging from international donors to national, provincial, and local governments to NGO/CSO/community-based organizations (CBO) actors – must buy into it.

2. Delivery of HIV-related Services

LINKAGES and its partners have made – and are continuing to make – significant contributions to the national HIV response in Thailand, ranging from the provision of essential HIV services to KPs, to the introduction and/or scale-up of innovations in the nature, scope, and delivery of these services.

Collectively, the various partners, including LINKAGES, the Thai Red Cross, the Ministry of Health, and the different implementing organizations, bring a compelling and unmatched mix of technical and operational expertise to the response. The more recent addition of the PULSE Clinic to the LINKAGES network has the potential to dramatically increase and improve the role of the private sector in the KP response in Thailand.

Strengths

- In Thailand, the drop-in center (DIC) approach has been a mainstay of HIV activities for KPs for many years (in Thailand these are referred to as Community Health Centers). Under LINKAGES, these centers continue to provide friendly, focused HIV services in safe spaces for these populations. LINKAGES/Thailand has also been instrumental in adding a basic set of clinical services (e.g., HIV testing and counseling, CD4 testing, STI screening) to the model, which has expanded the appeal and reach of the centers. Clients appear to appreciate the friendly, non-stigmatizing atmosphere and the quality of the integrated services.

Among knowledgeable parties, there is speculation that the need for safe spaces in Thailand has diminished, which means centers must develop new ways of maintaining relevance and connections with their primary clients. At many centers, clinical services have become the most prominent “feature” (i.e., the main draw for their clients). Assuming these clinics are providing services in a cost-effective manner – and that they are contributing to important LINKAGES targets (e.g., case detection/HTS_TST_POS) – the changing focus can and should be an important contribution to the HIV response.

- The EPM approach has proven to be an efficient and cost-effective way to improve HIV case detection, particularly among “hidden” members of the MSM and TG communities, including individuals who engage in HIV risk behaviors. The more progressive implementing partners have demonstrated the generally high value of recruiting and supporting HIV+ seeds to improve testing yields. Their evolving work with “super recruiters” is even more promising and has the potential to contribute to important refinements to the EPM approach; these refinements can and should be taken to scale across Thailand and shared with other LINKAGES countries who are not taking full advantage of EPM or the Enhanced Peer Outreach Approach (EPOA) version of the approach.
- The parallel social network scheme (SNS) model is also gaining traction in the field with early indications that it leads to a significantly higher HIV testing yield. As of FY 2018 Quarter I, the yield among 500 clients recruited via SNS was 11.6%.
- The eCascade management information system gives implementing partners access to “real time” data, which enables them to easily review and analyze service delivery information related to the EPM approach, including questions and prompts related to issues such as links or referrals to care and treatment and ongoing recruiting of EPM clients. In general, implementing partners have become more attuned to using data they collect about LINKAGES/Thailand activities as they become more familiar with eCascade, although the analysis tends to be fairly rudimentary.

Higher performing partners/sites appear to use a basic quality improvement approach to help analyze and act on the data.

eCascade is also useful in identifying “leaks” in the LINKAGES cascade that are negatively affecting partner performance. The View function of eCascade was seen as a plus because it makes the data more visual. In addition, the eCascade data from individual sites enables LINKAGES staff in Bangkok to better understand partner performance and provide targeted technical assistance.

- Outreach efforts continue to play a vital role in HIV-related work with KPs. Initial and sustained behavior change (e.g., testing uptake, condom use, PrEP, ART uptake, ART retention) with higher-risk individuals requires ongoing interaction with them, both in person and online. The increasing importance of online outreach has contributed to a positive evolution of outreach more generally with a greater emphasis on effectiveness and not simply reach or number of contacts. Consequently, LINKAGES/Thailand has taken steps to ensure the quality and efficacy of outreach work as a priority for its implementing partners, including, for example, using performance-based metrics to promote and track effectiveness. However, one of the greatest challenges with tracking and assessing outreach work is quantifying the number of interactions required to initiate and sustain behavior change, particularly with higher-risk and marginalized populations.
- The expanded use of PNs appears to be paying serious dividends. The ability of these outreach workers to contribute to performance improvements (i.e., reaching PEPFAR targets) across the expanded continuum should not be underestimated. For example, they are having an impact across the expanded cascade with responsibilities for prevention, testing, and treatment activities, including testing uptake, PrEP, and ART uptake and retention. The better PNs are functionally working as “case managers” whose ability to engage with KPs has a substantive effect on health-seeking behaviors.
- The effectiveness of outreach work is inextricably linked to the ability to refer clients to facilities that provide KP-friendly services. LINKAGES/Thailand has addressed this issue by building and strengthening the capacity of implementing partners to provide core services directly (e.g., rapid HIV testing, CD4 testing) and by helping implementing partners develop positive and productive relationships with government health officials, facilities, and front-line staff to deliver a broader range of appropriate services. (See above.)
- Although PrEP approval is still pending in Thailand, a high percentage (~58%) of individuals using the pills as part of an ongoing study have accessed them via LINKAGES-supported sites. Although the actual numbers of PrEP users served by LINKAGES/Thailand is modest (e.g., 676 new enrollees in FY 2018 Quarter I), performance against the PEPFAR target has been very good: 172% of the FY 2017 annual target. LINKAGES/Thailand does acknowledge it can and should be doing more to increase PrEP uptake and retention and is taking steps to do so, including a crowd-sourced contest promoting PrEP for young, high-risk members of the MSM and TG communities. As the PrEP discussion continues in Thailand, LINKAGES is well positioned to support its approval and scale-up, including providing field-level findings on client attitudes and behaviors.
- The expansion of services for members of the TG community has been an important development under LINKAGES/Thailand. Specialized facilities such as the Tangerine Clinic in Bangkok and the DIC/clinic at the Sisters Foundation in Pattaya have opened new avenues to

provide critical services to a population heavily affected by HIV, including testing, PrEP, referrals for ART initiation, and support for ART retention. The development of specialized facilities offering targeted services for this population also reflects the growing awareness that treating the MSM and TG communities as if they are homogeneous can undermine the appropriateness and effectiveness of key messages and services.

- The launch of a Same-Day ART (SDART) pilot by the Thai Red Cross in July 2017 is another initiative that has the potential to transform the HIV response in Thailand. In a country where the delays associated with the transfer of health rights can have a negative effect on ART initiation, including test-and-treat, the SDART pilot is proving to be an effective way to improve ART uptake while also using navigators to help set up long-term treatment arrangements for patients. The pilot is also a good example of collaboration within the LINKAGES network with Thai Red Cross working closely with two LINKAGES implementing partners in Bangkok, Rainbow Sky Association of Thailand (RSAT) and Service Workers in Group (SWING), to generate referrals for the SDART initiative. Plans for expansion of the SDART pilot to other locations (e.g., Chiang Mai) also leverage the strong relationships between LINKAGES implementing partners and the government health system.

Challenges

- Multiple stakeholders have questions about the accuracy of the size estimates of the different KPs, particularly at the local level. While accurate size estimates of these populations can be difficult to determine and are often controversial, having reasonable estimates is critically important for LINKAGES/Thailand, due in large part to the fundamental role they play in setting performance targets. In addition, there appears to be an absence of local – even hyperlocal – population size estimates, which are essential for good micro-planning and identifying where and how to efficiently and effectively implement activities.
- The mobile nature of KP populations and a shift away from traditional geographic boundaries because of the rise of virtual/online communities can limit the value of size estimates drawn from a single source or using a single methodology. Triangulation from multiple studies and/or alternative data sources can provide more accurate and up-to-date information about population size and potentially other related data points (e.g., hotspots, movement/migration, common behaviors).
- Micro-planning is an integral component of the LINKAGES approach globally, including Thailand. While it is used by implementing partners in Thailand, there is scope to strengthen consistent application of micro-planning by all implementing partners and to combine this with quality improvement practices (e.g., Plan-Do-Study-Act) to understand and address under-performance issues such as low testing yield or low uptake of ART.
- LINKAGES/Thailand recognizes there are “leaks” in the cascade. In general, leaks in HIV cascades are common and expected (e.g., drops between # reached and # tested). Even the 90-90-90 paradigm acknowledges drop-offs will occur. Stronger analysis of the reasons for the leaks at different points in the LINKAGES cascade and use of this analysis to address the leaks across all implementing partners would be beneficial.

This is not to say no analysis is done. It is clear from discussions with key stakeholders and from reviewing different reports that leaks in the cascade and the reasons for them are being assessed. For example, in FY 2017 Quarter 2-Quarter 3, LINKAGES/Thailand conducted a

qualitative assessment to better understand facilitators and barriers to ART uptake. Based on the results of the assessment, ranging from “case managers guidance through public health services” as a facilitator to “lack of privacy in clinical settings” as a barrier, LINKAGES/Thailand did undertake a series of activities to improve ART uptake.

Different LINKAGES/Thailand reports also capture the analysis of leaks in the cascade. For example, the FY 2017 Q4 report stated, “Underperformance on this indicator [TX_NEW] may be attributed to a number of factors, including lower-than-anticipated rates of case finding among HIV testing clients and an inability to report on treatment figures for clients who sought ART from providers unaffiliated with the LINKAGES project – either because they were required to do so under the Thai government social benefits scheme or for reasons of personal preference.”

Unfortunately, the analysis of leaks appears to be generally too far removed from the locations, activities, and constituencies where pragmatic changes need to occur if the problems are going to be solved. In addition, greater use could be made of quality improvement techniques at the site/partner level to better understand the root causes of the leaks and to identify practical solutions to address them.

- While the role of the drop-in center has evolved – e.g., the expansion into clinical services under LINKAGES/Thailand – this may need to be rethought and repositioned. Historically, they were important “safe spaces” for KPs as well as places where they could learn about HIV prevention, care, and treatment from health professionals, counselors and peers. However, the need for “safe spaces” appears to have declined due to multiple factors, including an increase in the number of alternative meeting places and the influence of online “spaces.” Given the scale of the investment in DIC-linked services and the history of innovation in Thailand, it is a missed opportunity to not take a more fundamental look at the future of these centers.
- The current approach to STI services within LINKAGES/Thailand limits the ability to use STI testing and treatment as a gateway to the provision of HIV testing and other essential HIV services. Although diagnosing and treating sexually transmitted infections (STI) is not a PEPFAR priority, access to STI services in the DIC/clinic can help to attract and retain KPs in HIV prevention, care, and treatment programs. For example, the prevalence of chlamydia, gonorrhea, HPV, and syphilis among MSM and TG populations – and the need to seek treatment for these infections – is an opportunity to engage with a broader cross-section of these communities, including hidden sub-populations and people who are at greater risk of contracting and transmitting STI of all kinds. Only doing basic screening for STIs and then referring for testing and treatment undermines the value of having clinical services. In contrast, the Anonymous Clinic at the Thai Red Cross provides a wide range of STI testing and treatment services, including services specifically for KP.

To its credit, LINKAGES/Thailand is working to improve the referral systems for STI services, which has the potential to improve access to these services. For example, discussions have been held in Chiang Mai with government and civil society about opening a KP-friendly STI clinic operated by the government with a streamlined referral system. The discussions are based on the premise that improved uptake of STI testing and treatment is vital as the use of PrEP grows among KPs in Thailand.

- LINKAGES/Thailand’s implementing partners are keen to organize events (e.g., concerts, parties, sports tournaments) as a way to attract new clients for HIV testing. Although there is limited

data on the effect these events have on testing uptake and case detection, there is some anecdotal evidence that they contribute to increased testing. Measuring the outcomes of these types of events, including improved prevention behaviors, HIV testing uptake, and ART retention, is difficult however, because many of the outcomes cannot be attributed to an individual event and are likely to unfold over a longer term. The success of the EPM approach – i.e., the positive yield from HIV testing – could also justify redirecting funds from events to expanding and refining the EPM approach.

- In Thailand, online activity is a robust and salient communications channel that should be tapped more strategically by LINKAGES and its partners. Online activities are increasingly important because they are reported to have replaced the “safe space” aspect of the drop-in center, which was an effective way to connect with members of KPs. They are also useful avenues for connecting with hidden and hard-to-reach populations, who may be more open to engaging in the online space. However, the current LINKAGES and LINKAGES-related online presence appears to be minimal and fragmented, with limited impact.

Again, LINKAGES/Thailand appears to be taking steps to improve the situation. For example, a pilot online promotion for HIV testing conducted in FY 2018 Quarter 1 could yield important lessons to strengthen its online – and its online-offline – presence. Given the online infrastructure in Thailand, LINKAGES’ commitment to innovation, and the importance of identifying effective online strategies and tools across LINKAGES globally, the team in Thailand should take a more coordinated, action-oriented approach to activities in this area, particularly initiatives to improve case detection and to expand PrEP knowledge and uptake.

- The existence of multiple identification systems in Thailand, e.g., national ID and national Unique Identifier Code (UIC) makes it difficult to track clients and monitor their interactions with HIV services. Aligning or centralizing existing systems and policies is beyond the scope of LINKAGES/Thailand but the lack of a national, coordinated UIC approach does complicate referral and monitoring of clients receiving services from LINKAGES’ partner organizations.

3. Community and Civil Society Engagement

LINKAGES benefits from a healthy and vibrant civil society sector in Thailand, which includes multiple HIV-focused organizations with the knowledge and skills to work with different KPs. These organizations tend to be led and/or largely staffed by members of these populations. Typically, the organizations are highly engaged and empowered to do their work.

Strengths

- The roster of CSO implementing partners used by LINKAGES/Thailand includes organizations with substantial knowledge and experience working in HIV response (e.g., Mplus, SWING, RSAT). They are solid, credible organizations who understand the challenges faced by KPs, including widespread stigma and discrimination that affects their health-seeking behaviors. In addition, they generally understand and respect the responsibilities of working with a donor such as USAID. Over the years, they have also received considerable technical assistance from donors to build their organizational and technical capacity.
- Members of KPs play prominent roles in the network of implementing partners, including in both civil society and private sector organizations. The majority of these organizations are led/managed by qualified individuals from the different KP groups. The primary benefit of

working with KP-led organizations is their credibility in the communities the project aims to serve and their ability to reach members of these communities.

- LINKAGES/Thailand has continued to build the capacity of partner organizations in ways that strengthen and expand their ability to provide services, meet targets, and contribute to epidemic control. Trainings on EPM, eCascade, and motivational interviewing (Motiv8) were seen as particularly useful in building targeted and relevant capacity. LINKAGES/Thailand should assess what type of training and technical assistance adds measurable value to the capacity of partner organizations to ensure that training is not being done simply as a pro forma exercise.
- The development of KP-centric clinics operated as adjuncts to traditional drop-in centers has created opportunities for implementing partners to provide services in a friendly and supportive setting. These services have contributed to greater engagement with the specific KP served by a specific clinic (e.g., the Tangerine Clinic for the TG community is a separate facility within the larger Anonymous Clinic operated by the Thai Red Cross in Bangkok). However, the separate nature of this service delivery model may not be feasible or sustainable in locations where there is a small client base.

Challenges

- Stigma and discrimination continue to be a major impediment to effective work with KPs in Thailand. They face stigma and discrimination from the general population related to their behaviors and lifestyles, and many are highly marginalized. For those who are infected with HIV, there is an additional HIV-related layer of stigma and discrimination. In addition, there are multiple reports of self-stigma within KPs, which further complicates strategies designed to limit their HIV risks and encourage uptake of HIV services.
- LINKAGES/Thailand has been active in addressing these various issues, but progress is constrained by the deep and pervasive social and cultural roots of stigma and discrimination in the country. Pragmatically, LINKAGES has focused on activities that directly affect the ability of KP clients to access and receive essential HIV services; for example, its work in training staff in health care settings to make services more KP-friendly has contributed to improved attitudes within KPs about health-seeking behaviors.
- While many of LINKAGES/Thailand's implementing partners are experienced, long-established organizations (e.g., Mplus, SWING, RSAT), they may not be best placed to reach higher-risk and hidden key populations, particularly those who are young and mobile. It would be useful to survey the CSO landscape in Thailand to identify potential new partners who may be better able to engage with these sub-populations and who are critical to reaching PEPFAR targets and achieving epidemic control.

4. Strategic Information

There is widespread commitment within LINKAGES/Thailand to the collection, analysis, and use of data that is relevant to its core activities, particularly those activities that are covered by the project's indicator set. This commitment is backed by an array of activities, ranging from M&E workshops, to data quality assessments, to data quality improvement exercises, to data visualization. There is a clear recognition that accurate strategic information is essential to improving performance across the board.

Strengths

- LINKAGES/Thailand has worked hard to develop a culture of improved data use among its implementing partners and its other collaborators, including Thai Red Cross and government counterparts at national, provincial, and local levels. For example, implementing partners tend to be conversant on their key data points and the trends they are seeing over time. As a historically data-driven organization, the Thai Red Cross has enthusiastically embraced LINKAGES' interest in data use in their joint efforts. Government counterparts at provincial and local levels seem increasingly eager to use data to understand the contributions of LINKAGES and to improve the management of their overall HIV response.
- Data tools such as eCascade and eCascade View are beginning to have a major impact on how implementers collect, analyze, and use data. Ongoing evolutions and upgrades of these tools, including the ability to export data for use in reporting, further extend their utility and increase their value at the partner/facility level.
- Steps are being taken to strengthen data quality across LINKAGES/Thailand with an expanded approach to data quality assessment (DQA) and data quality improvement (DQI). This approach is built around detailed steps to ensure data quality and site visits to provide technical support and independent verification of the efforts.
- At a micro level, counselors and peer navigators understand the importance of patient data in providing effective services. Much of this data is informal and qualitative and, consequently, is not captured by LINKAGES metrics, but it plays a fundamental role in the quality and effectiveness of the interaction of these staff members with their clients. It is the contextual data that helps them tailor their messages and support to best ensure positive behavior change (e.g., testing uptake, condom use, ART uptake/retention).

Challenges

- Despite the implementing partners being conversant with their data, much of their analysis of it tends to be fairly rudimentary. In many cases, it is as simple as recognizing that it shows where they stand vis-à-vis their targets. The basic nature of the analysis seems due in part to the absence of supporting data – typically qualitative – that would help them understand why things are or are not happening.
- In general, a lack of data or any substantive analysis of “why” is a recurrent shortcoming in the approach to strategic information and this makes it difficult to adjust implementation to improve performance and outcomes. LINKAGES is taking some steps to address this, for example, a six-month study has been conducted to improve understanding of barriers to uptake of ART among MSM.
- There are questions and concerns about the quality of the M&E databases operated by some of the implementing partners. LINKAGES/Thailand is aware of this problem and has been helping partners improve their databases and put in place the requisite systems to ensure their ongoing quality. The obvious challenge is the sustained level of effort required of the partners to maintain accurate and up-to-date databases.

Evaluation Question 3: What are the constraints to successful implementation of the program?

- Stigma and discrimination directed towards KPs as well as people living with HIV is a significant problem in Thailand. It negatively affects access to and uptake of HIV services that are essential to epidemic control. While LINKAGES/Thailand can work to limit the impact of stigma and discrimination in its spheres of influence, deep-seated fears and prejudices that underpin this stigma and discrimination require far broader and more sustained structural interventions than the project can tackle.
- The bureaucratic process of transferring health rights/benefits can be a serious disincentive for newly diagnosed clients to start ART and to stay on treatment. The government requirement that patients receive treatment in the location where they are registered for health care is generally problematic in Thailand because of the mobility of people and the difficulties of changing where they are registered. These problems are exacerbated for many members of KPs because of their higher mobility and the stigma and discrimination that complicates many of their interactions with government authorities.

LINKAGES/Thailand is working to address the issue of health rights/benefits in various ways, including empowering and equipping PNs to help with the transfer. The SDART pilot is a good example of how a thoughtful, systemic approach, which includes the use of PNs, can overcome a serious constraint to ART uptake and retention.

- Civil society organizations currently have limited ability and capacity to access domestic sources of funding to support their HIV activities. For services where domestic funding is available (e.g., testing/referral reimbursement through the NHSO, it is often difficult for CSOs to receive even a portion of the funds they are owed. As Thailand shifts to domestic funding mechanisms for its national HIV response, the lack of effective systems to channel funds to CSOs could have serious implications, given the vital role these organizations play in the response.
- There are multiple, free-standing health management information systems in Thailand, which complicates efforts to track patients across the cascade of HIV services. Plans are in place within the government to improve the integration of systems, including a replacement for Real-Time Cohort Monitoring that would be linked to the Routine Integrated HIV Information System. LINKAGES has been engaged with government to help move these plans forward.
- Despite a history of innovation in its HIV response, Thailand can be slow to approve new tools and approaches that would have clear benefits in the Thai context. For example, OraQuick and PrEP, which have been proven effective in both research and operational settings around the world, are on extended pilot testing in Thailand.

Evaluation Question 4: How well does the project align with PEPFAR and OHA global priorities and approaches?

The work of LINKAGES/Thailand is strongly aligned with PEPFAR and OHA global priorities and approaches, especially partnerships and work with KPs. The core PEPFAR and OHA commitment to partnerships is a fundamental component of the LINKAGES work in Thailand. The project has productive partnerships with government at national, provincial, and local levels; with technical/scientific organizations (e.g., Thai Red Cross); with CSOs; with community groups; and with the private sector. In addition, the project is aligned with the priorities of the national HIV response in the country, including the National AIDS Strategy (2017-2030), which prioritizes work with KPs.

The project's use of an expanded cascade to plan, implement, and measure its activities is also a clear reflection of its alignment with PEPFAR and OHA's commitment to epidemic control. LINKAGES readily acknowledges the importance of the 90-90-90/95-95-95 approach and objectives and their influence on its work.

In addition, the LINKAGES global and Thailand-specific focus on work with KPs is closely aligned with the priorities of PEPFAR and OHA. PEPFAR is very clear about its support for work with these populations, stating on its website: "PEPFAR stands firmly and unequivocally with and key populations. These groups include gay men and other men who have sex with men, people who inject drugs, sex workers, transgender persons, and prisoners." The website is equally clear about one of the primary reasons for working with these populations: "In almost every country in the world, members of these populations are at greater risk for HIV than the rest of the population. Globally, these key populations account for 45% of new HIV infections, according to UNAIDS, although they make up a much smaller proportion of the total population."

III. Recommendations

The network of LINKAGES partners in Thailand are doing important work with populations that must be reached with essential HIV services if epidemic control is going to be achieved in the country. The topline recommendation is to continue to invest in this work while also considering a set of course corrections to help improve performance and impact.

- **Reinforce the consistent and recurrent use of micro-planning by the implementing partners.** Micro-planning is a proven approach that can play a significant role in improving the effectiveness of the community-based activities at the heart of LINKAGES. One critical outcome is better data on population size and dynamics at the local/hyperlocal level, which is invaluable in identifying and implementing targeted activities linked to key objectives.
At its best, micro-planning is a day-to-day operational tool, not an occasional exercise. Combining micro-planning with basic quality improvement (QI) approaches could contribute to improved performance in areas where LINKAGES/Thailand is lagging.
- **Intensify efforts to reach high-risk and hidden populations.** The above-mentioned micro-planning should be attuned to the importance of reaching the high-risk and/or hidden populations where there is likely to be a greater number of undiagnosed HIV cases and a greater need for outreach support to contribute to sustained behavior change. EPM has proven effective and it should be scaled up as well as continually fine-tuned to explore ways to improve and sustain its effectiveness; the early promise of SNS should also be leveraged. In addition to working with existing partners to intensify case finding among these populations, LINKAGES/Thailand should see if other organizations that are better placed to find these populations could be included in the project.
- **Improve STI services at the DIC/clinic level.** LINKAGES/Thailand should accelerate the assessment of point-of-care STI diagnosis being explored by the project. Pending a positive outcome of the assessment, LINKAGES should push to pilot and/or fully deploy the diagnostic tools. LINKAGES should simultaneously accelerate efforts to improve referral services to KP-friendly STI clinics, including the use of PNs to assist in minimizing the hurdles for clients; this effort should build on the work being done with the government in Chiang Mai. In addition, it is

important to build the case for improved STI services by documenting the link between these services and better HIV case finding, particularly among high-risk and/or hidden populations.

- **Work with government partners to accelerate the timetable for approving new HIV-related interventions.** It is important for new interventions to be properly tested in Thailand before they are approved. However, piloting and approval can be a lengthy process, which limits the availability of important tools and technologies needed to improve the response. For example, approval is still pending which would allow scale-up of OraQuick HIV testing and PrEP; LINKAGES is advocating for this and reports that there is some progress.
- **Develop and implement a new, integrated, and inclusive online strategy for LINKAGES and its partners.** Recognizing that each implementing partner should have an online presence, it would be beneficial if LINKAGES/Thailand helped create and coordinate the messaging so that it is more effective. For example, the homegrown feel of partners' social media feeds belies the breadth, depth, and quality of the services they are offering. In addition, limiting the online strategy to LINKAGES partners ensures it has a narrow focus, making it less scalable and sustainable. For example, the TestBKK website, which only identifies nine gay-friendly HIV testing sites nationwide – all of them affiliated with LINKAGES – sends a misleading message about the availability of testing services for this population in the country. There may only be a limited number of LINKAGES-affiliated testing sites for this population, but it is highly likely there are other quality, KP-friendly testing sites in the country, which could be approved by LINKAGES.
- If the platform is sufficiently robust, LINKAGES/Thailand may also want to build on Outreach 3.0, the global LINKAGES initiative, which is designed to help members of KPs conduct their own risk screening, find competent local services, book appointments, and access virtual and anonymous support.
- **Continue to move toward case management as a way to improve performance across the cascade.** PNs at LINKAGES' implementing partners are increasingly acting as *de facto* case managers, who work closely with their clients to ensure they remain engaged in treatment and care. In countries around the world, case managers play a vital role in implementing differentiated care; for example, navigators in Laos allocate more of their time to clients who require more attention to adhere to their respective regimens than to stable patients who need less attention. LINKAGES/Thailand should consider how to better capture and convey the critical role that PNs play in ART uptake and retention to its key stakeholders, ranging from clients themselves to USAID and PEPFAR.
- **Build the case for the LINKAGES approach to be taken to scale with support from other funding and implementing partners.** In the sites where it is operational, the LINKAGES approach is improving the quality and effectiveness of the HIV response for KPs in Thailand. With ongoing fine-tuning, the approach should continue to improve its ability to detect new cases and increase ART uptake and retention. With the support of other organizations, ranging from international donors to national, provincial, and local governments to NGO/CSO/CBO actors, basic variants of the LINKAGES approach should be deployed widely in Thailand to ensure that marginalized populations have access to essential HIV services.

IV. Additional Questions

Program management

I. What are enabling factors supporting the implementation of the PEPFAR Incentive Fund (PIF) and barriers undermining its success?

The implementation of the PEPFAR Incentive Fund in Thailand has been affected by a diverse set of enabling factors and barriers, which, in some cases, are interlinked. However, the issue that has had the most direct impact on PIF implementation is the decision by the Global Fund to continue funding activities in Thailand beyond its planned end date. The original intent of the PIF was to facilitate the transition from Global Fund to domestic funding for work with KPs. On the one hand, the decision by the Global Fund to stay engaged in Thailand created more time and opportunity to prepare for the transition to domestic support for KP programs. On the other hand, the decision had a negative effect on PIF objectives because it reduced the urgency to shift to domestic funding for the KP component of the national HIV response.

An example of the link between enabling factors and barriers to success relates to the “imperative to implement.” Senior officials within the Ministry of Public Health (MOPH) acknowledge that the transition from Global Fund to domestic resources is a government priority. They highlight various activities as proof of their commitment, including: 1) the existence of sub-committees within the Department of Disease Control to look at the alignment of HIV funding streams; 2) ongoing meetings with Provincial Health Offices to discuss management, planning and monitoring and evaluation; 3) ongoing discussions about the Thai Fund; and 4) a costing study. Conversely, in other parts of government – specifically, the NHSO – there is some hesitancy about channeling domestic funds to civil CSOs, which appears to be based to a significant extent on a lack of historical precedent in its operations. NHSO also appears to be unwilling to make a commitment to funding CSO partners on par with the commitments they have to fund other service providers (e.g., government hospitals).

Despite the challenges, an increasing number of CSO partners across the LINKAGES network in Thailand are receiving reimbursement funds from Provincial NHSO offices for services provided. However, the LINKAGES partner that has been most successful in tapping NHSO reimbursements only gets about 50% of the amount they should receive. In addition, the approach proposed by NHSO to improve reimbursements includes steps that are either difficult for CSOs to take or out of sync with their mission.

It is important to note that NHSO reimbursements for CSOs will not cover the full cost of running a KP-focused HIV program or project. The government will need to identify other sources of funding for these when international support decreases. Examples of these other sources of funding include the NHSO 200 million THB (Thai baht) Fund, the Bureau of AIDS, Tuberculosis and STIs (BATS) 45 million THB for HIV prevention, and modest amounts of funding from some municipal governments.

As noted above, the decision by the Global Fund to delay its withdrawal from Thailand has reduced the sense of urgency within the government to address the situation. For example, establishing a Thai Fund was seen as a domestically funded alternative. While discussions about the Thai Fund have continued following the Global Fund decision to remain in Thailand, there are a number of unresolved issues, including which diseases it will cover and who would be eligible to receive disbursements, and it is unclear when or if it will be approved by the government.

Other enabling factors include: 1) the LINKAGES network in Thailand, which itself is built on long-standing USAID engagement with KP in the country and well-established relationships with CSO partners who work with these populations; 2) productive relationships with government at national and sub-national levels; and 3) productive relationships with other important stakeholders, such as the TRCARC and the Thailand MOPH and U.S. CDC Collaboration (TUC).

Other barriers to success include: 1) general lack of clarity about the PIF objectives, given the decision by the Global Fund to stay engaged in Thailand; 2) lack of understanding among LINKAGES implementing partners about the distinction between core project funding and PIF funding, including the distinction between the corresponding performance targets; 3) concerns about the accuracy and appropriateness of the PIF performance targets, particularly when added to the standard LINKAGES targets; 4) inconsistent definitions of accreditation, which is a proposed part of government reimbursement schemes; and 5) the fact that many CSOs are not prepared for the administrative demands of accepting funds from government sources.

Program accomplishments/results

2. To what extent and how have the PIF activities been implemented to support institutionalization of domestic financing systems?

Since the launch of the PIF, LINKAGES has invested time and resources to support the institutionalization of a domestic financing system in Thailand. A major focus has been engaging with NHSO at national and sub-national levels to improve the existing reimbursement mechanisms and explore other ways to disburse government funds to CSOs. As mentioned above, an increasing number of LINKAGES partners are now receiving reimbursements from NHSO, albeit less than they should receive. In the final quarter of FY 2017, provincial NHSO offices reported having contracts in place with LINKAGES partners for approximately 30 million THB in reimbursements for FY 2018. There also appears to be a willingness on the part of NHSO to facilitate a dialogue between Provincial Health Offices (PHOs), hospitals and CSOs that are already working together on how to direct and distribute funds to CSOs. Given the various issues in play, there are plans to extend discussions with NHSO about their role in funding CSOs in FY 2018.

LINKAGES has also been working with PHOs on their involvement in managing grants for CSOs. It appears that the basic processes and procedures are in place for PHOs to handle grant management; however, specific guidelines, which may need to be linked to individual donor requirements, have to be developed and agreed. LINKAGES reports that work on the guidelines is underway and provincial funding mechanisms for CSOs may be rolled out in the second quarter of FY 2018.

Discussions about issues related to domestic financing also appear to be part of the regular and ongoing dialogue with other LINKAGES stakeholders, including offices and departments within the MOPH, TRC-ARC, TUC, and CSO partners. In general, LINKAGES focuses on activities in areas where they have a direct interest (e.g., working with PHOs in provinces where LINKAGES partners are active; working on laboratory accreditation because community laboratories are a component of the LINKAGES approach in Thailand).

While some progress on domestic financing has been made, it is likely that the shift from Global Fund financing will be slow, particularly given the institutional barriers and the low imperative to transition. It is likely that any actions to increase the imperative and/or sense of urgency (e.g., hard deadlines for the end of a significant source of existing external financial support) would accelerate the transition to

domestic financing. However, there are corresponding risks associated with a deadline-driven approach to the transition, including reduced or eliminated funding for KP interventions.

2a. What progress has been made to support the financing of community-based services? In particular, this should be focused on the following:

2a (i). Implementation of and capacity building support for community-led HIV services, including HIV prevention, testing and treatment services

One of the core strengths of the LINKAGES project in Thailand has been its contribution to the implementation of and capacity building support for community-led HIV services. The ongoing work of the project's CSO partners is a testament to the financial and technical assistance provided by LINKAGES. The capacity of CSO partners to deliver quality services has clearly improved as a result of LINKAGES support. The main limitation of the work that LINKAGES has done in this area is the relatively small number of CSOs that have received support; however, one of the advantages of the way the PIF has unfolded is that it extended the reach of LINKAGES activities by funding work in previously unserved parts of the country.

From a financing perspective, the work done by LINKAGES to strengthen the operations of the CSO partners has helped to make them more viable, credible, and accountable, enabling them to become qualified recipients of domestic funds, ranging from block grants to reimbursements. As more partners handle increasing amounts of government funds in the form of NHSO reimbursements, it is likely they will need additional support to ensure they have sufficiently robust systems and capacity to meet NHSO requirements and expectations.

Consistently demonstrating their ability and reliability to efficiently and effectively manage their organizations and deliver quality HIV services to KPs is a vital way for the CSO partners to demonstrate their long-term role in the broader HIV response in Thailand.

2a (ii). Strategies and systems to sustain financing for community-led HIV services including HIV prevention, testing and treatment services

One approach taken by LINKAGES to secure sustainable government funding for community-led services is the accreditation of CSO laboratory facilities. Accredited laboratories are eligible to receive reimbursements as an NHSO Laboratory Node. LINKAGES has worked closely with TRC-ARC to support the accreditation of a laboratory operated by RSAT by the Thai Medical Technology Council (MTC). The RSAT laboratory in Songkhla is the first community laboratory to be accredited by MTC in Thailand, certifying its ability to provide testing services on a par with those of hospital laboratories in the country. LINKAGES – in collaboration with TRC-ARC – is planning to pursue accreditation of additional CSO partner laboratories in FY 2018.

Apart from this, and the efforts described above, LINKAGES appears to have made limited progress in developing and implementing strategies and systems to sustain financing for community-led HIV services in Thailand. While the efforts that have been made (e.g., increased NHSO reimbursements) are important steps towards domestic financing of the KP response, they are relatively small, reflecting the limited scale and scope of LINKAGES activities within the overall national HIV response.

Conclusions

It is clear the decision by the Global Fund to remain engaged in Thailand had a major impact on the objectives and activities of the PIF. However, despite the Global Fund decision, sustainable financing for community-led HIV services, including services for KPs, is an inevitable evolution of the HIV response in Thailand. The current level of urgency to transition to domestic financing may be low but any complacency about the lifespan of existing strategies and systems is dangerously shortsighted.

Using PIF funds to expand and extend the reach of LINKAGES activities has been beneficial on multiple levels, including: improved capacity of CSOs to provide much-needed HIV services to KPs, increasing numbers of KPs accessing services, expanded connections/relationships with government stakeholders in new provinces, and increasing numbers of CSOs with the capacity to tap existing government reimbursement schemes. But a sharper focus and an increased tempo of activities focused on the transition to domestic financing would have been and is still warranted. As mentioned above, the transition is inevitable and PIF has provided a vehicle and resources to drive the national discussion about the necessary changes.

Although there are political sensitivities, there are a number of areas where LINKAGES could do more to build the case for sustainable, domestic financing. For example, in response to the government's interest in accrediting CSOs as a precursor to their receiving government funds, LINKAGES – as a global USAID mechanism – could develop a “white paper” on relevant accreditation issues from both government and civil society perspectives. (A white paper of this type is likely to be broadly useful as other countries face declining international funding for their HIV responses and the corresponding need to explore other avenues for funding CSO and KP-focused activities.)

LINKAGES could also work with recognized experts to assess the legal and administrative barriers to direct CSO financing by the public sector and propose ways to address them. For example, the NHSO Secretariat has suggested three options for CBOs to secure domestic funding: 1) registration as a legal health facility under the central NHSO, 2) project-based contracts assigned to NHSO districts where hospitals have excluded CBOs, and 3) working as a node of a hospital and reimbursing costs through the hospital mechanism. LINKAGES could support an active dialogue on the strengths, weaknesses, and practical implications of this and other proposals with the aim of identifying feasible ways forward within a reasonable timeline.

Even something as simple as an accessible overview of the various issues related to increased domestic financing of the community response could be useful in the Thai context where the discussion appears to be very fragmented due to diverse institutional interests and biases.

Overall, there is an opportunity for LINKAGES to take a more proactive, solution-driven approach to the issue of sustainable financing. There are important champions within government who recognize the need to revise strategies and systems to reflect a greater reliance on sustainable, domestic financing. By working collaboratively with these champions, LINKAGES could make additional progress towards the PIF objectives of “1) demonstrating and disseminating sustainable policies and systems for domestic investments in the community response to HIV, and 2) demonstrating and disseminating enhancements and innovations that improve the effectiveness and efficiency of investments in community and clinical services.”

ANNEX VI. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

<p>USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project</p> <p>As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.</p> <p>Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:</p> <ol style="list-style-type: none">1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

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9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.



Signature

July 31, 2017

Date

David Hales

Name

Consultant

Title

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Signature

K Attawell

Date

14 October 2017

Name

K ATTAWELL

Title

Consultant

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Signature



Date

10/11/17

Name

Amie Bishop

Title

Consultant, Global Health and Human Rights; Director, Amie Bishop Consulting, LLC

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 - (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.



Signature

09/06/2017

Date

HUYGENS Pierre

Name

Social Scientist

Title

ANNEX VII. SUMMARY BIOS OF EVALUATION TEAM MEMBERS

David Hales, Team Leader, used his extensive experience in monitoring and evaluation to provide overall management and technical leadership for the evaluation of the LINKAGES project. He worked closely with other team members on all of the key components of the evaluation, including the development of the overall approach, the collection and analysis of information and data, and the writing of the final report. In addition, he led the team's visits to Angola, Laos, and Thailand.

Kathy Attawell, Evaluation Analyst and Writer, contributed to analysis of evaluation findings and analysis of LINKAGES data from the range of countries implementing activities for key populations. She drew on her extensive experience in different aspects of the HIV response, including program design, policy environment, aid effectiveness, structural interventions, and monitoring and evaluation. In addition to her work on the analysis, she was the primary author of the global report and a contributing author on the country-specific reports.

Amie Bishop, Senior Technical Expert, brought diverse knowledge and pragmatic expertise to the LINKAGES evaluation. Her extensive and multidisciplinary experience with project implementation was a vital component of the team's work. Her background in social work played an important role in the team's understanding and assessment of core issues in the evaluation, including stigma and discrimination and the role of civil society. She participated in the team's country visits to Haiti, Kenya, and Malawi.

Pierre Huygens, Senior Technical Expert, contributed his wide-ranging expertise on HIV-related interventions focused on reaching members of different key populations to the work of the evaluation team. His experience in conducting and assessing population size estimations was a critical resource for the team. In addition, his perspective as an organizational anthropologist provided invaluable insights on the role and operations of LINKAGES non-governmental organization/civil society organization partners. He participated in the team's country visits to Angola, Haiti, and Kenya.

For more information, please visit

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